Commonwealth of Kentucky

Personnel Cabinet

Department of Employee Insurance

Administration Manual

August 1, 2011

This manual will be updated throughout the year as KEHP establishes new processes due to KHRIS.

Personnel Cabinet
Department of Employee Insurance (DEI)
Kentucky Employees' Health Plan (KEHP)
501 High Street, 2nd Floor
Frankfort, KY 40601
www.kehp.ky.gov

DIVISION OF INSURANCE ADMINISTRATION

Enrollment Information Branch
(502) 564-1205
(502) 564-1085 (Fax)

Member Services Branch
(888) 581-8834
(502) 564-6534
(502) 564-5278 (Fax)

DIVISION OF FINANCIAL AND DATA SERVICES

Data Analysis Branch
(502) 564-7101
(502) 564-0715 (Fax)

Financial Management Branch
(502) 564-9097
(502) 564-0715 FAX
(502) 564-0350 Flexible Spending Accounts -FSA
(502) 564-0351 FSA
(502) 564-0364 FSA FAX

COMMISSIONER'S OFFICE
(502) 564-0358
(502) 564-5278 (Fax)

KEHP's Wellness Program
Access a variety of wellness services through
KEHPWELL Hotline and Website
877-KEHPWELL or (877-534-7935)
kehpwellonline.com

The Department of Employee Insurance does not administer Life Insurance benefits; however, the Kentucky Human Resource Information System (KHRIS) combines Life Insurance and Health Insurance information; therefore, the contact information for the Life Insurance Branch is listed below:

Personnel Cabinet
Office of Employee Relations, Life Insurance Branch
(502) 564-4774 or (800) 267-8352

INTRODUCTION
to the
KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

Self-Funded

KEHP is a non-profit, self-funded health plan, which means the Commonwealth assumes the risk of claims and pays an administrative fee to Humana, KEHP's Third Party Administrator (TPA), and to Express Scripts, Inc., the Pharmacy Benefits Manager (PBM), to process claims and to access provider networks.

KEHP Partners

Humana and Express Scripts, Inc., have established relationships with several business partners to assist with the administration of KEHP's business and to provide specialized services to our members. These partners have been approved by the Commonwealth of Kentucky and comply with all privacy regulations.

Humana

- **ActiveHealth Management** offers Informed Care Management (Disease Management), Case Management and Utilization Management programs to KEHP members.
- **Ceridian COBRA Continuation Services** administers COBRA continuation services for KEHP members. Ceridian uses an on-line enrollment system called WebQE as the method for COBRA notification. All Insurance Coordinators must enter an Employee's new hire and COBRA Qualifying Event information via WebQE. Ceridian is responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.
- **LifeSynch** partners with Humana to provide mental health and substance abuse services, as well as certain wellness benefits such as health coaching.
- **Virgin HealthMiles** partners with Humana to provide a walking/activity program to members of KEHP.

Express Scripts, Inc.

- **CuraScript Pharmacy** provides mail order services for certain oral and injectable specialty medications. Certain specialty drugs are required to be filled through CuraScript Pharmacy. Members will be allowed to fill the first prescription at the retail pharmacy, and after the first fill, Express Scripts will advise Members to fill future prescriptions through CuraScript Pharmacy.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a Dependent to the Plan who does not meet KEHP eligibility rules.

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CHAPTER 1:

ELIGIBILITY

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1. Eligible Participants

For the purposes of this manual, the term "Employee" includes regularly employed Employees, Retirees and/or beneficiaries, classified or certified school Employees and COBRA participants. Employees, Retirees and COBRA participants and/or their Dependents may only be covered under one state-sponsored plan.

A. Regularly Employed Employees: Employees of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in **KRS 18A.225**, are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- Quasi Agencies

B. Elected School Board Employees: Participate on a post-tax basis; the elected official is responsible for the total premium.

C. Retirees: Under the age of 65, or 65 or older and not eligible for Medicare, who draw a monthly retirement check from any of the following systems, are eligible to participate according to Plan guidelines:

- Judicial Retirement Plan (JRP)
- Legislators Retirement Plan (LRP)
- Kentucky Community and Technical College Retirement System (KCTCS)
- Kentucky Teachers' Retirement System (KTRS)
- Kentucky Retirement Systems (KRS) which include:
    - County Employees Retirement System (CERS)
    - Kentucky Employees Retirement System (KERS)
    - State Police Retirement System (SPRS)

Note: Retirees who are Medicare eligible and **actively** employed with a participating company must contact their retirement system to determine if they must drop their Medicare Supplement Plan. These Employees are eligible to participate in KEHP, and must be provided the opportunity to participate.

D. COBRA Qualified Beneficiaries: Employees and/or eligible Dependents who elect COBRA coverage through KEHP.

E. Dependents: The following Dependents are eligible for participation through KEHP:

- An Employee or Retiree's Spouse
- An Employee or Retiree's child under the age of 26 and NOT eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer

F. Disabled Dependents: For purposes of KEHP, a Dependent may continue to be covered under the Plan beyond the age limit if the disability started before the limiting age and is medically certified by a physician. A total disability is defined as the condition that results when any medically determinable physical or mental

condition prevents a Dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. Humana may require proof of the Dependent's disability at least annually. Disabled Dependents not covered under the Plan prior to the limiting age may only be enrolled in KEHP if they lose other Health Insurance coverage. If you wish to enroll a disabled Dependent who is past the limiting age specified under the eligibility rules, you must show proof that the disabled Dependent has experienced a loss of coverage. Other than Open Enrollment, the request to add the disabled Dependent must be made within 35 calendar days of the Qualifying Event (loss of coverage).

G. Members with End Stage Renal Disease (ESRD): KEHP members who were diagnosed with ESRD before becoming Medicare eligible remain eligible for KEHP coverage for the first 30 months of Medicare eligibility. This rule applies whether or not the Member has reached age 65.

H. Active Employees and Dependent Spouses <u>Age 65 or Older</u>

- An **active Employee** age 65 or older and eligible for Medicare is eligible for coverage in KEHP under the active employer.
- A **Dependent Spouse** age 65 or older and eligible for Medicare is eligible for coverage in KEHP under the active employer.

The Medicare eligible active Employee is treated like any other regularly employed Employee and may elect or waive coverage in KEHP.

Note: All benefit plans offered through KEHP, including the Stand-Alone, Waiver HRA, will be primary over (i.e. pay before) Medicare.

Note: The Insurance Coordinator for the active employer must give an active Employee nearing the age of 65 or an Employees age 65 or older, the notice of KEHP options, upon becoming eligible for Medicare by sending the Employee a copy of the *Notice to Active Employees 65 or Older* (Appendix A).

2. Dependent Eligibility Chart - Dependent eligibility rules and verification requirements are contained in the following chart. Dependent verification for Qualifying Events must be submitted with the Qualifying Event documents. Qualifying Event enrollment documents must be signed within the event timeframe.

Eligibility Definition	Documentation Required
Spouse A person of the opposite sex who is legally married to an Employee or Retiree.	A legible photocopy of the Marriage Certificate OR a legible photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040)
Common Law Spouse A person of the opposite sex with whom you have established a Common Law union in a state which recognizes Common Law Marriage (Kentucky does not recognize Common Law Marriage).	A legible photocopy of the Certificate or Affidavit of Common Law Marriage from a state that does recognize Common Law Marriage.
Child Age 0 to 18 **In the case of a child who has not yet attained his/her 19th birthday**, "child" means an individual who is – • A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or • An eligible foster child of the Employee/Retiree (eligible foster child means an individual who is placed with the Employee/Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or • An adopted child of the Employee/Retiree (a legally adopted individual of the Employee/Retiree, or an individual who is lawfully placed with the Employee/Retiree for legal adoption by the Employee/Retiree) or • A grandchild for whom the Employee/Retiree has been awarded guardianship or custody by a court of competent jurisdiction.	**Natural Child**: A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree as a parent. **Step Child**: A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree's Spouse as a parent; **and** a legible copy of the marriage certificate showing the names of the Employee/Retiree and the Spouse. **Legal Guardian, Adoption, Grandchild(ren) or Foster Child(ren)**: Legible photocopies of Court Orders, Guardianship Documents, Affidavits of Dependency, with the presiding judge's signature and filed status; **or** legible Adoption or Legal Placement Decrees with the presiding judge's signature.
Child Age 19 to 25 **In the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday**, "child" means an individual who is – • A son, daughter, stepson, stepdaughter, eligible foster child, an adopted child or a grandchild of the Employee/Retiree – as described above; **AND** • NOT eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer.	Must submit the documents described above for children and the **Kentucky Employees' Health Plan 2011 Certification of Dependent Eligibility Form.**
Disabled Dependent A Dependent child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A disabled child who was not covered on this Plan prior to his/her 26th birthday may not be enrolled in KEHP unless he/she sustains a specific qualifying event.	Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed.
Cross Reference Payment Option A payment option involving two Employees/Retirees who are a legally married couple and enroll themselves and at least one child as a Dependent in a KEHP family plan.	Documentation listed above to verify Spouse and children.

3. Retirees

Retirees from a Kentucky sponsored retirement system **may not be eligible for** a Medicare Supplement Plan offered through the retirement system. These Retirees should contact their retirement system to determine whether they are eligible for a plan through the retirement system.

When Retirees reach age 65, they will receive a letter stating whether or not they are Medicare eligible.

Retirees who have not returned to active employment, and who become eligible for Medicare are no longer eligible participants in KEHP (See KRS 18A.225), EXCEPT in cases of End Stage Renal Disease (See paragraph 1.G). The retirement system must send a termination notice to KEHP terminating the Retiree due to Medicare eligibility. If the Medicare letter states that the Retiree does not qualify for Medicare, the retirement system must submit the letter to KEHP to show that the Retiree is still qualified to remain on the Plan.

Insurance Coordinators should refer each "return-to-work" Retiree who is Medicare-eligible and participating in a KRS, KTRS or Judicial/Legislative Retirement system to the appropriate retirement system for a determination of whether the Employee must terminate the Medicare Supplement Plan.

A. KRS Retirees Who Return-to-Work

- and are not Medicare eligible have the option to select coverage either through KRS or through the active employer.
- are not eligible for an employer contribution **and** a contribution from a retirement system.
- may enroll in KEHP through KRS and waive coverage through the active employer.
- may waive coverage with KRS and enroll in KEHP through the active employer.
- may waive coverage with KRS and waive coverage through the active employer and enroll in the stand-alone Waiver HRA.
- may elect to participate in a Healthcare or Dependent Care FSA through the active employer.

B. KTRS Retirees Who Return-to-Work

- must waive coverage with KTRS and enroll in KEHP through the active employer.
- may waive coverage with KTRS and waive coverage through the active employer and enroll in the stand-alone Waiver HRA.
- are not eligible for an employer contribution **and** a contribution from a retirement system.
- may elect to participate in a Healthcare or Dependent Care FSA through the active employer.

C. Retirees Age 65 or Older Who Return-to-Work

- must be offered an opportunity to enroll in KEHP through the active employer. If coverage is elected through KEHP, the Retiree will receive an employer contribution toward KEHP coverage from the active employer.
- may elect to participate in a Healthcare or Dependent Care FSA through their active employer.
- and are eligible for, and elect a Medicare Supplemental Plan (partial eligibility constitutes Medicare eligibility) offered by a Kentucky retirement system, are **not** eligible for state funding through the active employer.

D. Deceased or Medicare Eligible Retiree's Beneficiary (The individual designated by the Retiree as his or her beneficiary, or filed with the retirement system)

- may apply to enroll in KEHP when experiencing a Qualifying Event that allows the beneficiary to enroll (such as loss of other coverage) or during Open Enrollment.
- may "take over" the plan and become the Planholder, if the Retiree's beneficiary is a Dependent/Spouse on the plan. Coverage must be elected within 35 days of the loss of coverage.
- must contact the retirement system within 35 days of the death of the Retiree. (If a Retiree's beneficiary is not a current Spouse or Dependent on the plan, the retirement system will determine eligibility dates). The death of the Retiree in itself may not be a Qualifying Event that would allow the beneficiary to enroll in the plan.

E. Spouses of Retirees

A Spouse of a Retiree who is covered under the Retiree's plan AND who is actively employed is not eligible to waive health insurance coverage and receive the employer contribution into an HRA (commonly referred to as double-dipping) due to KRS 18A.225 (12) which reads:

> *Any Employee who is eligible for and elects to participate in the state health insurance program as a Retiree, or the Spouse or beneficiary of a Retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a Retiree and an active Employee Spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that Plan Year. (Emphasis added).*

4. Eligibility for the Employer Contribution

A. Agencies Covered Under KRS 18A and Technical Schools

- After the initial waiting period for new hire, Employees are eligible for the employer contribution for the current semi-monthly period if during the previous semi-monthly period, they use:
    - any combination of workdays;
    - paid leave; and/or
    - Family Medical Leave.

- Employees returning from leave without pay (LWOP) must work at least one day in the previous semi-monthly period to qualify for the employer contribution for the current semi-monthly period.

- Employees must work at least one day (or have paid leave) during the previous semi-monthly period in order to be eligible for the employer contribution for the next period. Coverage for Employees who do not meet this requirement should be terminated and the Employee must be offered COBRA continuation coverage.

NOTE: Semi-monthly period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of the Employee's pay schedule.

B. Agencies NOT Covered Under KRS 18A

- After the initial waiting period for new hire, Employees are eligible for the employer contribution for the current semi-monthly period if during that semi-monthly period, they use:
  - any combination of workdays;
  - paid leave; and/or
  - Family Medical Leave.

- Employees returning from leave without pay (LWOP) must work at least one day in the semi-monthly period to qualify for the employer contribution for that semi-monthly period.

- Employees must work at least one day (or have paid leave) during the semi-monthly period in order to be eligible for the employer contribution for that semi-monthly period. Coverage for Employees who do not meet this requirement should be terminated and the Employee must be offered COBRA continuation coverage.

NOTE: Semi-monthly period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of the employee's pay schedule.

C. Quasi Governmental Agencies

Insurance Coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies for the definition of a regularly employed Employee entitled to employer contributions.

D. Dual Employment

An Employee who is considered regularly employed for two participating employers (and meets the eligibility requirements for each employer) is eligible for the employer contribution from each employer. However, an Employee is only eligible to participate in one KEHP Health Insurance plan. Therefore, a dual Employee may enroll in a KEHP Health Insurance plan through one employer and waive KEHP coverage through the other employer and enroll in a Waiver HRA, if eligible, or waive coverage through both employers and enroll in a Waiver HRA with both.

CHAPTER 2:

ENROLLMENT

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1. Initial Enrollment

Coverage for new Employees will begin on the first day of the second calendar month following the Employee's hire date. Example: if employment begins anytime in August, the Employee is eligible for coverage October 1.

New Employees may make their elections online in KHRIS or they may complete an Enrollment Application within the first 35 calendar days of employment.

Employees who fail to make their Health Insurance elections or waive their coverage within the designated time frame will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. **Employees who fail to enroll will automatically be defaulted to a forced waiver. Forced waivers do not receive any funds in an HRA; it is merely a waiver of benefits**.

2. Initial Enrollment for Quasi-Governmental Agencies

Insurance Coordinators for Quasi-Governmental Agencies should refer to their company's administrative regulations or internal policies and then apply the following rules for new hires:

- If the quasi-agency has a three or more month waiting period (1st day of the 3rd month, 1st day of the 4th month, etc.) begin counting the 35 days from the Effective Date of coverage and count backwards.
- If the quasi-agency has a two month waiting period as mentioned above in Initial Enrollment, the Employee has 35 days from the date of hire to enroll in KEHP coverage to become effective the first day of the second month.

Example: If the quasi agency has a four month waiting period before KEHP coverage begins (new hires are effective the 1st day of the 4th month) and the New Employee is hired on January 1, KEHP coverage will become effective May 1. The Employee must enroll anytime between March 27 and April 30.

Employees who fail to make KEHP elections or waive coverage within the deadline will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. **Employees who fail to enroll will automatically be defaulted to a forced waiver. Forced waivers do not receive any funds in an HRA; it is merely a waiver of benefits**.

3. Waiving Health Insurance Benefits

Employees who do not wish to enroll in a Health Insurance plan with KEHP may waive their Health Insurance benefits and receive a Waiver HRA. The HRA is funded with $175 employer contribution per month or $2100 per calendar year. Not all Employees are eligible to receive the HRA when coverage is waived. Refer to Chapter 7 and the HRA Summary Plan Description for more details. Employees may elect to waive Health Insurance coverage in KHRIS, or they may elect to waive Health Insurance on the Enrollment Application. Waiving coverage must be completed within the timeframe in "Initial Enrollment" or "Initial Enrollment for Quasi-Governmental Agencies" above.

A. Waiving Health Insurance and receiving an HRA (Waiver HRA) is only permitted

- during the annual Open Enrollment period;
- for new Employees;
- for Employees with an 11 or more working day break in service (in employment);
- for Employees who experience a different Open Enrollment that occurs between KEHP's open enrollment and December 31 (i.e. between mid October and December 31); or
- for Employees returning from Military Leave who are remaining on TRICARE.

B. Waiving Health Insurance with NO HRA (Forced Waiver)

Employees who do not waive Health Insurance and receive the Waiver HRA in the KHRIS system or who do not complete an Enrollment Application electing to waive Health Insurance (the Employee does nothing) will be defaulted automatically to a "forced waiver" which has no HRA funds.

C. Redirection of the Employer Contribution

Redirection is the ability of an Employee to stop employer funds from going into a Waiver HRA in order to start receiving an employer contribution toward a Health Insurance plan. Refer to the Qualifying Event Charts in Chapter 5 for more information on which QEs allow redirection.

Employees who are enrolled in a Health Insurance plan **will not** be allowed to terminate coverage and enroll in a Waiver HRA in the middle of a Plan Year, unless the Employees:

- have had a working day break in service of more than 11 scheduled working days;
- have experienced a different Open Enrollment period that occurs between KEHP's Open Enrollment and December 31 (i.e. between mid October and December 31). This only applies to changes to be effective the beginning of KEHP Plan Year – no mid-year election changes are allowed for this situation;
- have returned from military leave and are remaining on TRICARE; or
- have experienced a permitted Qualifying Event.

4. Open Enrollment

Open Enrollment is a period of time for Employees to make KEHP elections for the upcoming Plan Year, which runs from January 1 to December 31 each year. Open Enrollment requirements may vary during each Open Enrollment period. KEHP will provide specific Open Enrollment guidelines to all Employees during each period.

After Open Enrollment elections have been made, Employees may only change their elections under very specific circumstances. Such changes are regulated by federal law and are referred to as "permitted election changes" or Qualifying Events under the federal regulations. The requested change must always be consistent with the Qualifying Event.

All changes are permitted during Open Enrollment with the following exceptions: 1) Employees cannot drop Dependent children for whom they are required by an administrative order to provide coverage (if the enforcement of the order is directed to the employer), including National Medical Support Orders; 2) Employees cannot add a previously un-covered disabled Dependent (DD) who is over the age limit.

5. Transition from Dependent Child to New Employee

Adult children who are regularly employed full-time by a participating KEHP employer are not eligible to continue benefits under their parent's KEHP plan. Adult children are defined as children who are at least 19 years old, but not yet 26 years old.

The newly hired Dependent child(ren) must enroll and follow all initial enrollment guidelines.

The Dependent must be dropped from the parent's plan and the child's termination date as a Dependent ends on the day prior to the Effective Date of the child's coverage as an active Employee (Planholder).

6. Newly-Hired Employees, Transfers and Rehires to a KEHP Participating Company

New Employees are Employees newly hired by a company. They may or may not have worked for another KEHP participating company as of the business day prior to their hire date with your company. In order to determine the Effective Date of coverage with your company and whether or not newly hired Employees are allowed to make changes to their KEHP elections, review the scenarios below.

A. Newly-Hired Employees With No Prior Employment with a KEHP Participating Company

- The Effective Date of KEHP elections will be the first day of the second calendar month following the hire date. *Example*: if employment begins anytime in August, Employees are eligible for coverage October 1.
- The newly hired Employee may enroll in KEHP or waive Health Insurance coverage and enroll in the stand-alone HRA (Waiver HRA), if eligible.

B. Newly-Hired Employees Who Are Transferring From Another KEHP Participating Company - <u>WITHOUT</u> a Break in Employment

- The newly-hired transferring Employee is considered a "clean" transfer.
- The Effective Date of KEHP elections is the first day of the semi-monthly period following the termination date of coverage with the previous company. This may require your company to begin providing the employer contribution for the month in which the Employee was hired.

  Example: Employment begins on August 1 and the Employee's last day of work with the previous employer was July 31; the new company must provide coverage and the employer contribution for the month of August.

- The newly-hired transferring Employees who do not have a break in service are NOT permitted to make new KEHP elections. The Insurance Coordinator must "hire-in" employees in KHRIS with the transfer reason code or submit an Update Form with the transfer information. In some instances the newly-hired transferring Employee may terminate employment at one company at the end of a week (before a weekend) and begin employment with the new company at the beginning of the next work week (usually Monday), or during a holiday. Employees in this situation will be considered to have had no break in employment because weekends and/or holidays are not regularly scheduled working days.

  Note: Employees whose "weekends" fall in the middle of the week rather than Saturday and Sunday will have their regularly scheduled days count as a weekend, and will not count as a break in service. Please notify KEHP if this occurs for appropriate adjustments.

C. Newly Hired Employees Who Are Transferring From Another KEHP Participating Company – <u>WITH</u> a Break in Employment

1. Break in service of 1 to 10 working days:

- Considered a "small break" transfer.
- May experience a half month break in KEHP coverage elections.
  - If the 1 to 10 day break occurs in the same semi-monthly pay period there is no break in coverage.

- If the 1 to 10 day break occurs within different semi-monthly pay periods, there is a ½ month break in coverage.

- Employees with a "small break" transfer are not allowed to make new KEHP coverage elections. These Employees will be allowed to make new coverage elections only if they experienced a Qualifying Event (all Qualifying Event guidelines apply) or if an Open Enrollment period coincides with the break in employment. If this is the case, the Employees must follow Open Enrollment guidelines and submit an Enrollment Application.

Example 1: No Break in Coverage: Employee stops working at old company 7/19, Health Insurance stops on 7/31. The Employee is hired by a new company on 7/24, with Health Insurance beginning on 8/1. This Employee does not experience a break in coverage.
Example 2: Half Month Break in Coverage: Employee stops working at old company 8/10, Health Insurance stops on 8/15. The Employee is hired by a new company on 8/18, with Health Insurance beginning on 9/1. This Employee will have a ½ month break in coverage (from 8/15 to 8/31).

2. Break in employment of 11 or more working days:

- Considered new Employees and are treated as such for enrollment and eligibility.
- The Effective Date of their Health Insurance elections is the first day of the second calendar month following their hire date. *Example*: If employment begins anytime in August, the Employees are eligible for coverage October 1.
- As new Employees they are allowed to enroll in any available plan, waive Health Insurance coverage and enroll in the Waiver HRA if eligible, make changes to smoking status if needed (all enrollment procedures, deadlines and restrictions apply).

Example: Employee stops working at old company 2/10, Health Insurance stops on 2/15. The Employee is hired by a new company on 2/22, with Health Insurance beginning on 4/1. The Employee will have a 1 ½ month break in coverage. However, with the new company, the Employee is allowed to make new KEHP elections as well as change his/her smoking status, if needed.

CHAPTER 3:
COVERAGE LEVELS
&
CROSS-REFERENCE PAYMENT OPTION

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1. Coverage Levels

KEHP offers four Coverage Levels to choose from when making Health Insurance elections.

A. Single Coverage Level: Covers the Employee.

B. Parent Plus Coverage Level: Covers the Employee and one or more eligible children.

C. Couple Coverage Level: Covers the Employee and the Employee's Spouse.

D. Family Coverage Level: Covers the Employee, Spouse and one or more eligible children.

2. Cross-Reference Payment Option

The Cross-Reference Payment Option is a legislatively mandated payment option that offers lower Employee premiums which are deducted from both Employees' paychecks. Employees must satisfy all requirements below to elect the Cross-Reference Payment Option.

A. Requirements

- The Employees must be legally married with at least one Dependent;
- The Employees must be Eligible Employees or Retirees* of a group participating in KEHP;
- The Employees must elect the same coverage option; and
- The Employees must both enroll in KHRIS, or complete an Enrollment Application complete with signatures from both Employees and Insurance Coordinators.

Failure to meet any one of the above requirements will make the Employees ineligible for the Cross-Reference Payment Option.

**Per the Judicial and Legislators Retirement System, Retirees of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.*

B. Electing the Cross-Reference Payment Option

Experiencing a Qualifying Event: When two Employees experience a Qualifying Event, which will allow their plans to merge into one cross-reference payment option, one Employee may change their Plan Option to begin a Cross-Reference Payment Option. This is not a Qualifying Event to allow both Planholders to elect a new Plan Option (i.e. if they have two different Plan Options, they must select which plan they desire). The Employee with the oldest hire date will become the primary Planholder.

1. At the Time of Hire with a Participating Group: The newly-hired Employee must elect coverage to match the existing Employee/Retiree's elections and the existing Employee will become the primary Planholder. If the existing Employee has waived Health Insurance and the existing Employee, newly hired Spouse, or Dependent has experienced a loss of coverage, the Employee must sign and date the Enrollment Application requesting to begin a Cross-Reference Payment Option within 35 calendar days of the loss. Depending on how the dates fall, the existing Employee may have to pay full family premium for the first month.

Example: Jane Doe works for a board of education. She waives her Health Insurance coverage and receives the Waiver HRA. Her Spouse, John, is hired by the local health department, losing his Health Insurance with his former company. John elects to start a cross-reference payment option with Jane, effective June 1. The first step Jane must take is to establish herself as a Planholder with a Health Insurance plan. She must submit a Loss of Coverage Qualifying Event (loss of coverage from her Spouse's former employer). If her

Qualifying Event is effective before June 1, she must start her insurance as a non-cross-referenced member. Then, June 1, she may switch to the Cross-Reference Payment Option with her Spouse John.

2. **During Open Enrollment:** Employee with the oldest hire date will be the primary Planholder.

3. **At retirement:** Retirees who are newly retired and with a participating retirement system can elect the Cross-Reference Payment Option, if applicable. The new Retiree must elect coverage to match the existing Employee/Retiree's elections and the existing Employee becomes the primary Planholder. If the existing Planholder is a Retiree (not an active Employee), the existing Retiree is primary Planholder until Open Enrollment, at which time they may switch Primary/Secondary status. The active Employee will always be the primary Planholder for cross-reference; the Retiree will be the secondary Planholder.

C. Ending the Cross-Reference Payment Option

1. **Termination of Employment or Loss of Employer Paid Benefit Eligibility:** If either Employee loses employment/eligibility for any reason, the Cross-Reference Payment Option terminates since eligibility to participate in the Cross-Reference Payment Option has ceased.
    - The remaining Planholder will automatically default to a Parent Plus Coverage Level. If desired, the remaining Planholder may change Coverage Level to a Single Coverage Level. A Dependent Drop Form must be received within 35 calendar days after the date of the Qualifying Event.
    - If the Dependent Drop Form does not indicate the Coverage Level or is not received within 35 calendar days, the default Coverage Level will remain in effect until the next Open Enrollment period, or a permitted Qualifying Event occurs, and the Employee may not change Plan Option.
    - If the remaining Planholder wishes to add the former Employee to the Plan, the Planholder MUST request the change to their Coverage Level (Parent Plus) within 35 days of the loss of Planholder status in order to have a Family Coverage Level.

2. **New Retirement:** Newly retired Retirees of a participating retirement system may elect to cancel their Cross-Reference Payment Option. The Spouse of the new Retiree will be enrolled in a Coverage Level that corresponds to the new Retiree's Coverage Level. No Plan Option changes will be allowed for the active Employee.

3. **Either Participant Loses Eligibility for Coverage Due to LWOP**

4. **Qualifying Event:**

    - If the Employee experiences a Qualifying Event that allows the Spouse to be dropped from the Plan. Changes in Plan Options will NOT be allowed.
    - If the Employee experiences a Qualifying Event that allows the only Dependent child to be dropped from the Plan. In this situation, the covered Employees will be assigned to two Single Coverage Level plans. Changes in Plan Options will NOT be allowed.

An Employee in a Cross-Reference Payment Option who terminates employment IS eligible for COBRA coverage. Insurance Coordinators must enter these Employees in Ceridian's WebQE.

CHAPTER 4:

TERMINATION of COVERAGE

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1. Health Insurance Coverage Termination

If Employees terminate employment between the 1st and the 15th of the month, their Health Insurance coverage will terminate on the 15th of the same month.

If Employees terminate employment between the 16th and the end of the month, their Health Insurance coverage will terminate on the last day of the same month.

Example: An Employee terminates employment on March 5; Health Insurance coverage terminates on March 15. If an Employee terminates employment on March 25; Health Insurance coverage terminates on March 31.

The Employee's premium will be deducted automatically from the Employee's check for state agencies and boards of education. In the event there is not enough money in the last paycheck to cover the premiums due, employers should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.

The Insurance Coordinator must terminate the Employee in KHRIS or submit an Update Form listing the Employee's last day of employment. **Terminations must be entered within 10 days of the occurrence**.

The Insurance Coordinator must also enter the termination information on Ceridian's WebQE to notify Ceridian to mail COBRA information to the affected Employee and any Dependents to offer continued Health Insurance coverage. This is a federal requirement and fines may be incurred if COBRA notification is not processed in a timely manner. Employees who terminate employment before benefits take effect are not eligible for those benefits and, therefore, not eligible for COBRA.

A. Loss of Dependent Eligibility

Dependent children and/or Spouses who become ineligible for coverage under the Plan (other than for attaining the limiting age) will be terminated at the end of the month they cease to meet the dependency requirements, whether the 35-day requirement notification has been met or not.

Dependent children who become ineligible under the plan due to attaining the limiting age will be terminated at the end of the calendar month in which the birthday occurs.

B. Retirees

Retirees who are Medicare eligible and not actively employed will be terminated at the end of the month before becoming Medicare eligible.

1. **If Dependents are currently enrolled in the Plan**, they may apply to become the Planholder. If the Spouse or Dependent chooses to become the Planholder, and later die leaving remaining Dependents on the Plan, Health Insurance coverage will terminate at the end of the month following the date of death. In both cases above, the Retiree is not deceased.

2. **If there are no Dependents currently enrolled in the Plan**, coverage terminates at the end of the month before becoming Medicare eligible.

C. Death of an Employee or Dependent

1. Single Coverage Level

If the Employee dies on the 1st through the 15th of the month, Health Insurance coverage will terminate on the Employee's date of death. No premiums are due. If the Employee dies on the 16th through the end of the month, Health Insurance coverage will terminate on the Employee's date of death. The full month contribution is due.

2. Parent Plus, Couple or Family Coverage

If the Employee dies, Health Insurance coverage for the covered Dependents will continue to the end of the month in which death occurs. The full month contribution is due. If a Dependent dies and the death causes a Coverage Level change (e.g. family to parent plus), the original level of Health Insurance coverage will continue to the end of the month in which the death occurred and the full month premium is due. The new level of coverage will begin the 1st of the next month and the new contribution will begin.

The Insurance Coordinator should notify the family of the date the last paycheck will be issued; contact information for the appropriate retirement system; name and phone number of the Plan's administrator; and additional Employee payroll deductions and company contacts. The Insurance Coordinator must enter the Qualifying Event on Ceridian's WebQE system.

D. Death of a Retiree

1. Single Coverage Level

If the Retiree dies and has Single Coverage, coverage will terminate on the end of the month in which the death occurs.

2. Parent Plus, Couple or Family Coverage Level

If the Retiree dies and has a Parent Plus, Couple or Family plan, coverage will terminate the end of the month in which the death occurs. The current beneficiary may apply, within 35 calendar days from the date of death to take over the plan.

The Insurance Coordinator should submit an Enrollment Application to KEHP with the new Planholder's insurance elections.

E. Death of a Retiree's Beneficiary

If the Retiree's beneficiary dies and has Single Coverage Level, coverage will terminate on the date of death.

If the Retiree's beneficiary dies and has a Parent Plus, Couple or Family Coverage Level, it will terminate the end of the month in which the death occurs.

2. Leaves of Absence

Health Insurance ONLY - Refer to Chapter 12 for Flexible Benefits

A. Leave Without Pay (LWOP)

The following LWOP guidelines apply to eligibility for KEHP and are not meant to replace any LWOP guidelines established by a company. While an Employee is on LWOP the following could occur:

1. New Employees Beginning LWOP Before Health Insurance Coverage Begins:

In some instances a new Employee may go on LWOP before the Effective Date of Health Insurance coverage, in this case the following rules will apply if the Enrollment Application has been completed and signed within the required 35 day period after the hire date.

Health Insurance coverage will be effective on the **"later of"** the following two dates:

- The 1st day of the second month following the date of hire or
- The 1st day of the pay period following the pay period in which the employee returns from LWOP.

However, if the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

2. Beginning LWOP

- **KRS Chapter 18A Agencies and Technical Schools (780 KAR 6:062):**
  Employees on approved LWOP (except education LWOP) must work **at least one day in the previous semi-monthly period** (the first through the 15th or the 16th through the end of the month) to be eligible for the Commonwealth employer contribution for Health Insurance for the next period. An Employee can be on intermittent LWOP and continue to be eligible for the employer contribution for Health Insurance as long as the Employee works at least one day during each previous semi-monthly period.

- **Non KRS Chapter 18A Agencies:**
  Employees on approved LWOP must work **at least one day during the semi-monthly period** (the first through the 15th or the 16th through the end of the month) to be eligible for the Commonwealth employer contribution for Health Insurance for that period. An Employee can be on intermittent LWOP and continue to be eligible for the employer contribution for Health Insurance as long as the Employee works at least one day during each semi-monthly period.

  However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

- **702 KAR 1:035 School Board Employees:**
  According to the regulation above, LWOP will include the beginning of the first day of the month following an employee's last paid working day.

3. Extended LWOP

If an Employee is on approved LWOP and does not work at least:

- **KRS 18A Agencies and 780 KAR Agencies:** one day during a semi-monthly period (the first through the 15th or the 16th through the end of the month) the Employee will not be eligible for the employer contribution for Health Insurance for the next period.
- **Non-KRS 18A Agencies:** one day during each semi-monthly period (the first through the 15th or the 16th through the end of the month) the Employee will not be eligible for the employer contribution for Health Insurance for that period.

The Insurance Coordinator must either enter the LWOP action in KHRIS or submit an Update Form to KEHP providing the Employee's approved LWOP begin date and the Health Insurance termination date (end of the semi-monthly period). The Insurance Coordinator must enter the information into Ceridian's WebQE System.

Examples: These examples apply to KRS 18A Agencies and KAR 780 Agencies:

- Employee on approved LWOP or suspension and works one day during the period of the 1st through the 15th
  - Health Insurance ends the last day of the month.
- Employee works at least one day between the 16th and the end of the month.
  - Health Insurance ends on the 15th of the following month.
- If the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

Examples: These examples apply to Non-18A Agencies:

- Employee on approved LWOP or suspension and works one day during the period of the 1st through the 15th.
  - Health Insurance ends on the 15th of the same month.
- Employee works at least one day between the 16th and the end of the month.
  - Health Insurance ends on the last day of the same month.
- If the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

4. LWOP and the Cross-Reference Payment Option

If an Employee is on LWOP and loses coverage, the Cross-Reference Payment Option must be broken. KEHP will notify the remaining Spouse's Insurance Coordinator that one of the Employees is on LWOP and the remaining Employee will be defaulted from a Cross-Reference Payment Option to a Parent Plus Coverage Level.

If the remaining Planholder wishes to elect a Single Coverage Level, a Couple Coverage Level or a Family Coverage Level to include the Employee on LWOP, they MUST complete an Enrollment Application to change Coverage Levels within 35 days of the loss of Planholder status. The remaining Planholder would then be responsible for the total Employee contribution for the plan. If LWOP results in a loss of coverage, the Insurance Coordinator must enter the event in Ceridian's WebQE system.

5. Returning from LWOP-Eligibility for the Employer Contribution

KRS Chapter 18A Agencies and Technical Schools (780 KAR 6.602)

Employees who return from approved LWOP or suspension must work at least one day in the PREVIOUS semi-monthly period to be eligible to receive the employer contribution for the current period.

Example: Employee returns from approved extended LWOP or suspension.

Employee works at least one day between the 1st and the 15th of the month
- Health Insurance starts on the 16th of the current month

Employee works at least one day between the 1st and the 15th of the month
- Health Insurance starts on the 1st of the next month

However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

Non-18A Agencies or KAR 780 Agencies

Employees who return from approved LWOP or suspension must work at least one day in the CURRENT semi-monthly period to be eligible to receive the employer contribution for the current period.

Employee works at least one day between the 1st and the 15th of the current month
- Health Insurance starts on the 1st of the current month

Employee works at least one day between the 16th and the end of the current month
- Health Insurance starts on the 16th of the current month

However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

702 KAR 1:035 School Board Employees

Employees who return from approved LWOP will be eligible for the employer contribution when they have actively returned to work at least one day of the next consecutive month after being on LWOP.

However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

6. Returning from LWOP-Eligibility for Coverage Level Changes

Employees who return to work after being on approved LWOP will automatically be reinstated to the elections they had prior to LWOP status, unless the previous plan is no longer offered.

Employees who return to work after being on approved LWOP will not be eligible to make any changes to their insurance coverage unless:

- they experience a Qualifying Event and apply for an appropriate Coverage Level change no later than 35 days from their return to work date.
- they return in a new Plan Year and they were on approved LWOP during the Open Enrollment period. They must apply for a Coverage Level change no later than 35 days after the return.

7. When Employees are on LWOP the following may occur:

An Open Enrollment Period

- Employees who are on LWOP during the Open Enrollment period will not receive an Open Enrollment packet.
- Employees who elected COBRA will receive Open Enrollment packets from the COBRA administrator.
- Upon returning to work, the Employees are entitled to receive the Open Enrollment information from the Insurance Coordinator. Employees will have 35 days from the date they return to work to make their Open Enrollment elections.

The Employees Experience a Qualifying Event

- Employees on LWOP who experience a Qualifying Event must follow the same Qualifying Event rules as other Employees. However, they must request the mid-year election change within 35 days from the return to work date.
- The same rules as defined in the Returning from LWOP section will be applied to determine the Effective Date of coverage.

8. Additional LWOP Information

- When there is a loss of coverage, the Insurance Coordinator must submit an Update Form to the Department of Employee Insurance indicating the Employee is on LWOP or suspended. The Insurance Coordinator must also enter the event in Ceridian's WebQE system to ensure the Employee is notified of their rights under COBRA. The Insurance Coordinator must also submit an Update Form to **reinstate** the Employee's Health Insurance when the Employee regains eligibility.
- The Commonwealth of Kentucky's regulations which address LWOP for Employees of executive branch agencies are set forth in 101 KAR 2:102, Section 2 (2)(c) (Classified leave administrative regulations); and 101 KAR 3:015, Section 2 (2)(c) (Leave administrative regulations for the unclassified service). According to the amended regulations (July 15, 2009):
    - An Eligible Employee for state contributions for health benefits under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than education leave, during any part of the previous pay period.
- If an Employee fails to submit appropriate premium payments due within the specified deadline, the ENTIRE Health Insurance plan will be canceled. If this occurs, the Insurance Coordinator should request a refund of any employer contribution amount paid.
- When an Employee is granted approved extended LWOP, the Insurance Coordinator must send the Guidelines for Benefits While on Approved LWOP memo.
- Workers' Compensation – being on Workers' Compensation or being hurt on the job has no effect on LWOP or an Employee's Health Insurance coverage. However, if an Employee goes on extended LWOP the Employee loses eligibility for Health Insurance coverage.

- As an employer, agencies who participate in KEHP may have different guidelines for administering LWOP programs; this guidance is established for Health Insurance and FSA coverage only.

B. Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed 12 months of service and worked or been on paid leave at least 1,250 hours in the 12 months preceding the first day of FMLA leave. This leave is available annually.

The Employees may choose to:

- use paid (annual, sick or compensatory) leave concurrently with FMLA leave (101 KAR 2:102);
- use unpaid leave during the FMLA leave; or
- reserve 10 days of accumulated sick leave prior to being placed on FMLA leave.

When Employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E). While Employees are on unpaid FMLA, they may choose to keep their Health Insurance and Flexible Spending Account(s) active. Refer to the Qualifying Event Charts in Chapter 5 for the specific payment options.

Employees on unpaid FMLA and enrolled in a Healthcare FSA may elect COBRA.

Employees on unpaid FMLA and enrolled in a Dependent Care FSA are NOT eligible for COBRA benefits for the Dependent Care FSA. However, if IRS regulations are met, the Employee on unpaid FMLA may continue to file Dependent care claims for the remaining funds in their account until the end of the Plan Year.

NOTE: Being on Workers' Compensation or being hurt on the job has no effect on FMLA or Health Insurance.

1. Starting FMLA leave

Starting FMLA leave is not a Qualifying Event to change KEHP elections. When Employees begin FMLA leave, the employer contribution for Health Insurance must continue through the leave period. Employees are responsible for the Employee's share of the Health Insurance contributions. Employees may choose to:

- Cease contributions (terminate entire plan);
- Prepay the coverage contributions for the FMLA leave period;
- Choose the pay-as-you-go method. If Employees choose this method of payment the Employee's premiums are due at the same time premiums would be due if made by payroll deduction.

Non-Commonwealth Paid premiums are due on the 15th and Commonwealth Paid premiums are due on the 5th of the month in which leave begins. The Insurance Coordinator must collect the premium check (payable to the Kentucky State Treasurer) and forward it to the Financial Management Branch, Department of Employee Insurance, Personnel Cabinet, 501 High Street, 2nd floor, Frankfort, Kentucky 40601.

2. During FMLA

When an Employee is on FMLA, the following may occur:

An Open Enrollment Period

- Employees who are on FMLA during Open Enrollment and are still covered through KEHP will receive an Open Enrollment packet from their Insurance Coordinator.
- Employees who choose to cease contributions, which stop coverage, are not eligible for Health Insurance under the Kentucky Employees' Health Plan (KEHP) until they return to work. If the Employee returns to work, they will have 35 days to make Open Enrollment elections.

Employees experience a Qualifying Event

- Employees on FMLA who experience a Qualifying Event will have 35 days from their return to work date to request a status change.

3. Returning from FMLA leave

- Employees returning from FMLA leave, where coverage was stopped during the leave must be reinstated to the prior elections unless there has been an intervening status change, in which case, the Employees will have 35 days from their return to work date to request a status change.
- If the Employees chose to suspend Health Insurance coverage during the FMLA leave, the Employees may be reinstated to the prior elections on the day they return to active status.
    - If the Employee is reinstated between the 1st and the 15th of a month, the Employees will be responsible for payment of premiums for the entire month at the new Coverage Level, if applicable.
    - If the Employee is reinstated between the 16th and the end of a month, the Employees will be responsible for payment of premiums for the one half month of reinstatement at the new Coverage Level, if applicable.
- If the Employee had coverage cancelled due to non-payment of premiums, the Employees are to be reinstated to the prior elections upon payment of all past-due premiums.
- If the Employee chose suspension of coverage or fails to pay past-due premiums, the company is to request a refund of the employer contribution for the applicable months.

4. Not returning from FMLA leave

When Employees have exhausted FMLA leave, but do not return to work (begin LWOP), the Insurance Coordinator must notify the Employees of their COBRA rights (if eligible), regardless of their insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for 18 months of COBRA coverage.

C. Paid Leave

Employees who have worked or been on paid leave (annual, sick or compensatory time) for at least one day during a semi-monthly period will be eligible for the state contribution for that half of the month. Paid leave must be used consecutively.

D. Military Leave

Employees called to active military duty are eligible for health benefits through the United States government. The Employee's Dependents may also be eligible for military Health Insurance.

1. Beginning Military Leave

Employees may stop their Health Insurance coverage on the last day of the semi-monthly period in which they are activated with the Armed Services. This option will allow Employees to start their Health Insurance coverage immediately upon return to active employment. This stop-and-start process will in no way negatively impact Employees with regard to pre-existing conditions.

Employees may elect to maintain their current level of Health Insurance coverage, as well as maintain military health care coverage. They must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 15th day of the month of the coverage month for Non-Commonwealth Paid Employees, and the 5th day of the month of the coverage month for Commonwealth Paid Employees. All premiums due upon return from active duty will be determined by the date of return to active employment.

2. During military leave

If Employees elect to maintain their Health Insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 15th day of the month of the coverage month for Non-Commonwealth Paid Employees, and the 5th day of the month of the coverage month for Commonwealth Paid Employees. The premium would include the total monthly premium (Employee and employer cost) if the Employee does not have paid leave status.

3. Returning from military leave

Employees returning from military leave will have all benefits (Health Insurance and Flexible Spending Accounts) reinstated the date they return, (first day of the second month rule does not apply) without any waiting period.

Employees returning from military leave have the option to delay the reinstatement of their prior elections until military coverage ends. During that time, Employees may waive coverage and enroll in a Waiver HRA until TRICARE. Employees electing this option MUST present supporting documentation of the military coverage end date and coverage will be reinstated the first day of the month following the date of the loss of coverage through TRICARE.

Employees returning between the 1st and the 15th of the month will need to pay the Employee portion (Family, Couple, Parent Plus or Single Coverage Level, if applicable) of the insurance premium for the month of return. Employees returning on the 16th of the month or later will be responsible for one-half month premium.

CHAPTER 5:

QUALIFYING EVENTS

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1. Qualifying Events

KEHP is provided through a Section 125 plan per the Internal Revenue Code. This allows Employees to pay for their Health Insurance premiums with pre-tax dollars. Section 125 plans are federally regulated. Federal guidelines state that if Employees' Health Insurance or Flexible Spending Account is offered through a Section 125 plan, they cannot make a change to their Health Insurance or Flexible Spending Account options outside of the Open Enrollment period unless they experience a permitted election change (referred to as Qualifying Events). Qualifying Events are governed by federal guidelines.

A. To Enroll in KEHP Outside of the Annual Open Enrollment Period the Individual Must:

1. Lose Coverage From:

- An employer-sponsored group health plan;
- An individual Health Insurance plan (must lose eligibility) ;
- A short-term, limited-duration insurance policy also known as "gap" insurance;
- A student Health Insurance policy; or
- A government coverage (TRICARE, Medicare, Medicaid, KCHIP)

*Losing coverage from one of the following **does not allow** the individual to enroll outside of the annual open enrollment period:*

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- VA Benefits;
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Lose Coverage Due To:

- A maximum benefits level being reached;
- An insurance agency canceling the policy (other than for non-payment);
- Coverage being provided under COBRA and COBRA has expired;
- Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage (including but not limited to: legal separation, divorce, end of Dependent status, death of an Employee, termination of employment, reduction in hours) or employer contributions for coverage were terminated; or
- The plan no longer offers benefits for a group of individuals.

Not Due To:

- Non-payment of insurance premiums – choosing to stop payment of a plan for any reason;
- Non-renewal – choosing to stop renewal of a plan for any reason;
- Cancellation of coverage by policyholder for policyholder or for a Dependent;

- Increase in cost of coverage (unless for Dependent care FSA); or
- Reduction of contributions or level of benefits.

B. General Guidelines

A Section 125 Cafeteria Plan gives guidelines for processing Qualifying Events for Health Insurance, Healthcare FSA, Dependent care FSA and Waiver HRAs. After the annual Open Enrollment period, an Employee must experience a Qualifying Event to add or drop Dependents, or under appropriate circumstances make other permitted changes.

1. Event Date

The Event date is the date the event occurs. It is not the date the Employee or Dependent is notified of the event. The **only exceptions** to this are:

- Entitlement to CHAMPVA
- Entitlement to TRICARE
- Medicare
- Medicaid

In the instances above, the Qualifying Event date can be the date the Employee or Dependent is notified.

2. Signature Date

The Signature Date is the date the Employee's signature is on the applicable documentation. Most Qualifying Events have a signature deadline of 35 calendar days from the Event Date. However, some have a signature deadline of 60 calendar days from the Event Date. It is important to know the deadlines for the Signature Date for all Qualifying Events.

To calculate the number of calendar days, begin counting on the day after the Qualifying Event.

*Example***:** If the Employee gets married on March 5, the Employee must sign the applicable forms within 35 calendar days from the event (marriage). Day one would be March 6, and day 35 would be April 9. The Employee's signature must be on the applicable forms no later than April 9.

Pre-Signing

Applicable forms may not be signed prior to the event date, except for the following:

- Loss of other health coverage;
- Gaining other health coverage;
- Entitlement to Medicare; and
- Spouse's different Open Enrollment period.

The timing of the signature date is critical. Employees must complete the Enrollment forms and sign the applicable forms <u>before</u> the signature date deadline. The Employee does not need to wait for any supporting documentation to arrive before the form is signed.

3. Effective Date

The Effective Date is the date the coverage takes effect. Most effective dates are the first day of the month following the signature date. Coverage can NEVER be effective prior to the Event Date. Always consider the following:

- If the Qualifying Event date is the first of the month, the Employee may pre-sign during the previous month.

  Example: If "loss of coverage" occurs on April 1, the Employee may sign the applicable documentation during the month of March. The Effective Date of the change will be April 1.

- If the Qualifying Event date is any other day of the month, the Employee may pre-sign during that month only.

  Example: If "loss of coverage" occurs on April 18, the Employee may sign the applicable documentation during the month of April. The Effective Date of the change will be May 1.

4. Qualifying Event Charts

The next several pages are the Qualifying Event charts. Use the charts as your guide in knowing what mid-year election changes are permitted, and what documentation is required.

QUALIFYING EVENT	MARRIAGE

Health Insurance	Permitted	
Adding Employee, Spouse and/or Dependent(s) including Tag-alongs	Yes	
Make Coverage Level or Plan Option changes if adding Dependent(s)	Yes	
Make Plan Option change when not adding Dependent(s)		No
Dropping Dependent(s) if Employee gains coverage under Spouse's plan	Yes	
Make Plan Option change if dropping Dependent(s)	Yes	
Redirecting the employer contribution to a Waiver HRA		No
Healthcare FSA	**Permitted**	
Enrolling in or increasing election	Yes	
Decreasing election if family members become covered under Spouse's plan	Yes	
Dependent Care FSA	**Permitted**	
Enrolling or increasing election if marriage increases Dependent care expenses	Yes	
Decreasing election if family members becomes covered under Spouse's plan or marriage decreases Dependent Care FSA expenses	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance	Yes	

Event Date	
Adding Employee and/or Dependent(s)	Date of the marriage
Dropping Dependent(s)(if other coverage gained)	Date Dependent gained other group Health Insurance coverage under the Spouse's plan

Signature Deadline	35 calendar days from the event date

Effective Date	Cannot be effective before the event date
Adding Dependent	First of the month following the Employee's signature on the Enrollment Application, Dependent Add Form or FSA Enrollment/Change Application
Dropping Dependent	End of the month of the Employee's signature on the Dependent Drop Form
Enrolling/increasing FSA	First day of the month following Employee's signature date
Terminating/decreasing FSA	End of the month of the Employee's signature date

Document(s) Required	If adding, must also submit eligibility verification documents
Adding Spouse	See Dependent Eligibility Chart – Chapter 1, Page 3
Adding Dependent(s)	See Dependent Eligibility Chart – Chapter 1, Page 3
Dropping Dependent(s) due to gaining other group Health Insurance	Letter from employer, on employer's letterhead, identifying the coverage effective date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, stating the coverage effective date

Forms to Use	
Enrolling	Enrollment Application or FSA Enrollment/Change Application
Adding Dependent(s)	Dependent Add Form plus eligibility verification documents
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application plus eligibility verification documents
Dropping Dependent(s)	Dependent Drop Form
Changing FSA	FSA Enrollment/Change Application

QUALIFYING EVENT	DIVORCE, LEGAL SEPARATION OR ANNULMENT

Health Insurance	**Permitted**	
Adding Employee and Dependent(s) if losing coverage under Spouse's plan	Yes	
Dropping Spouse	Yes	
Dropping Dependent only if adding to former Spouse's plan	Yes	
Dropping Dependent children who cease to meet eligibility requirement under KEHP (children of former Spouse no longer eligible)	Yes	
Changing Plan Option if **not** adding Dependent(s)		No
Changing Plan Option if dropping Dependent(s)	Yes	
Healthcare FSA	**Permitted**	
Enrolling in or increasing election	Yes	
Decreasing election if family members become covered under Spouse's plan	Yes	
Dependent Care FSA	**Permitted**	
Enrolling in or increasing election if event increases Dependent Care FSA expenses or causes loss of coverage under Spouse's plan	Yes	
Terminating or decreasing election if event decreases Dependent Care FSA expenses	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance (if event causes loss of coverage under Spouse's plan)	Yes	

Event Date	
Adding Employee/Dependent(s)	Date of loss of coverage under former Spouse's plan or the date the divorce decree is entered by the court.
Dropping Spouse/Dependents	If Dependent ceases to meet eligibility requirements under KEHP, event date is the date of divorce decree, annulment or legal separation is entered by the court.

Signature Deadline	35 calendar days from the event date. Note: Event makes Spouse ineligible even if 35 days not met. Former Spouse must be dropped at the end of the month of ineligibility.
Effective Date	Cannot be effective before the event date
Adding Dependent	First of the month following the Employee's signature on the Application, Dependent Add Form or FSA Enrollment/Change Application
Dropping Spouse or Dependent(s)	End of the month in which the divorce, legal separation or annulment occurred.
Dropping Dependent(s) added to other group plan	When added to former Spouse's plan, the end of the month following Employee's signature on the Dependent Drop Form
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date
Document(s) Required	If adding Dependents, must also submit eligibility verification documents
Adding	HIPAA Certificate of Creditable Coverage; letter from Employer on letterhead that includes person(s) covered and coverage termination date; letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or termination letter from governmental agency providing previous coverage.
Dropping	Divorce decree signed by judge and date stamped "filed" or "entered"; or legal separation papers signed by judge and date stamped "filed" or "entered" or annulment papers signed by judge and date stamped "filed" or "entered".
Forms to Use	
Enrolling	Enrollment Application or FSA Enrollment/Change Application
Adding Dependents	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Dropping Dependents	Dependent Drop Form
Changing FSA	FSA Enrollment/Change Application

QUALIFYING EVENT	SPOUSE'S DEATH

Health Insurance	Permitted	
Adding Employee and/or Dependent children including Tag-alongs, if coverage is lost due to Spouse's death.	Yes	
Dropping deceased Spouse from plan	Yes	
Changing Plan Option if adding Dependent(s)	Yes	
Changing Plan Option if **not** adding Dependent(s)		No
Changing Plan Option if dropping Spouse or Dependent(s)	Yes	
Healthcare FSA	**Permitted**	
Enrolling in or increasing election if death caused a loss of coverage under Spouse's health plan	Yes	
Terminating or decreasing election	Yes	
Dependent Care FSA	**Permitted**	
Enrolling in or increasing election if event increases Dependent Care FSA expenses or causes loss of coverage under Spouse's plan	Yes	
Terminating or decreasing election if event decreases Dependent Care FSA expenses	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance **if event causes loss of coverage under Spouse's plan**	Yes	

Event Date	
Adding Employee/Dependent(s)	Date of loss of coverage under deceased Spouse's plan.
Dropping Deceased Spouse	Date of death.
Signature Deadline	35 calendar days from the event date

Effective Date	Cannot be effective before the event date
Adding Dependent	First of the month following the Employee's signature on the Enrollment Application, Dependent Add Form or FSA Enrollment/Change Application.
Dropping Spouse or Dependent(s)	End of the month of the Spouse's death. The new plan, if applicable, will be effective the first day of the following month, regardless of whether the 35 day deadline is met.
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date. **Possible refund of FSA:** Refund only if Member paid for complete month and died before the 15th of the month.
Document(s) Required	If Adding, must also submit eligibility verification documents
Adding	HIPAA Certificate of Creditable Coverage; Letter from Employer on letterhead that includes person(s) covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.
Dropping	If dropping deceased Spouse - none.
Forms to Use	
Enrolling	Enrollment Application or FSA Enrollment/Change Application
Adding Dependents	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Drop Dependents	Dependent Drop Form
Drop Deceased Spouse	Dependent Drop Form
Changing FSA	FSA Enrollment/Change Application

QUALIFYING EVENT	BIRTH, ADOPTION, PLACEMENT FOR ADOPTION

Health Insurance	Permitted	
Adding new child, Employee, Spouse or other Dependent children including Tag-alongs	Yes	
Changing Plan Option when adding Dependent(s) or Spouse	Yes	
Healthcare FSA	**Permitted**	
Enrolling in or increasing election	Yes	
Dependent Care FSA	**Permitted**	
Enrolling in or increasing election if event increases Dependent Care FSA expenses.	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance	Yes	

Event Date	
Adding Employee/Dependent(s)	Birth - Date of Birth Adoption - Date of Adoption; Foreign Adoption- Date Visa stamped Placement - Child's Placement Date

Signature Deadline	
Adding **ONLY** a newborn, adopted or placed child	60 calendar days from the event date
Adding newborn, adopted or placed child **PLUS** other Dependent(s)	35 Calendar days from the event date
Effective Date	Cannot be effective before the event date
Adding	Birth – Date of Birth Adoption – Date of Adoption; Foreign Adoption – Date Visa stamped Placement - Child's Placement Date
Adding which results in a Coverage Level Change	If the birth creates a Coverage Level change, no increase in costs until the 32 day from date of birth If the birth plus Tag-alongs creates a Coverage Level change • between the 1st and the 15th day of the month, the Member must pay the new premium for the entire month • between the 16th and the end of the month, the Member must pay the new premium for one-half of the month.
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Document(s) Required	If Adding, must also submit eligibility verification documents
Adding	See Dependent Eligibility Chart – Chapter 1, Page 3
Forms to Use	
Enrolling	Enrollment Application or FSA Enrollment/Change Application
Adding Dependent(s)	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Changing FSA	FSA Enrollment/Change Application
Special Notes:	
New Rule – Effective 05/01/11	When a newborn baby is added to KEHP, no premiums will be charged for the first 31 days, unless Tag-alongs are added at the time of the newborn's birth. See Appendix J.

QUALIFYING EVENT	SPOUSE OR DEPENDENT LOSES OTHER EMPLOYER-SPONSORED HEALTH COVERAGE (due to termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under the employer's plan etc.)

Health Insurance	Permitted	
Adding Employee, Spouse, and/or Dependent(s), including Tag-alongs, if event causes a loss of coverage under Spouse's or Dependent's health plan	Yes	
Changing Plan Option when adding Dependent(s) or Spouse	Yes	
Healthcare FSA	**Permitted**	
Enrolling in or increasing election, if event causes loss of coverage under Spouse's or Dependent's health plan	Yes	
Dependent Care FSA	**Permitted**	
Enrolling in or increasing election, if event causes loss of eligibility for coverage under Spouse's Dependent Care FSA	Yes	
Terminating or decreasing election, if event decreases Dependent Care FSA expenses	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance if event causes loss of coverage under Spouse's plan.	Yes	

Event Date	
Adding Employee/Dependent(s)	Date of loss of coverage under the other employer-sponsored group health plan
Signature Deadline	35 calendar days from the Qualifying Event date.

Effective Date	Cannot be effective before the event date
Adding Spouse or Dependent(s)	The first day of the month following the Employee's signature date on the application or Dependent Add Form. **The application or Dependent Add Form may be signed by the Employee prior to the loss of coverage.**
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date
Document(s) Required	If Adding, must also submit eligibility verification documents
Adding Spouse or Dependent(s)	HIPAA Certificate of Creditable Coverage; Letter from Employer on letterhead that includes person(s) covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.
Forms to Use	
Enrolling	Enrollment Application or FSA Enrollment/Change Application
Adding Dependent(s)	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Changing FSA	FSA Enrollment/Change Application
Special Notes:	
COBRA	Some employers may offer a few months of COBRA to terminated Employees as a part of a severance package. IT IS IMPORTANT to note that the end of employer-paid COBRA coverage is NOT a Qualifying Event that would allow enrollment in KEHP, as the COBRA continuation coverage period has not been exhausted. Only expiration of COBRA is considered loss of other coverage.

QUALIFYING EVENT	**SPOUSE OR DEPENDENT <u>GAINS</u> OTHER EMPLOYER-SPONSORED HEALTH COVERAGE** (due to starting employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under an employer's plan).

Health Insurance	**Permitted**	
Dropping Employee, Spouse and/or Dependent(s) who become covered under Spouse's or Dependent's health plan	Yes	
Changing Plan Option when dropping Dependent(s) or Spouse	Yes	
Healthcare FSA	**Permitted**	
Decreasing or terminating election, if family becomes covered under the health plan of Spouse or Dependent	Yes	
Dependent Care FSA	**Permitted**	
Enrolling or increasing election, if event increases Dependent Care FSA expenses.	Yes	
Terminating or decreasing election, if family becomes covered under Spouse's Dependent Care FSA	Yes	
Waiver HRA	**Permitted**	
Does not apply, no change allowed.		No

Event Date	
Dropping Employee, Spouse or Dependent(s)	The date the person being dropped gained coverage under the Spouse's or Dependent's employer sponsored group health plan.

Signature Deadline	35 calendar days from the Qualifying Event date.

Effective Date	Cannot be effective before the event date
Dropping Employee, Spouse or Dependents	The end of the month in which the Employee signed the Dependent Drop Form or Enrollment Application. The Enrollment Application or Dependent Add Form may be signed by the Employee prior to gaining coverage.
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
Dropping Employee, Spouse or Dependent(s)	Letter from employer, on employer's letterhead, identifying the coverage effective date and the person(s) covered by the policy; or Copy of new Health Insurance ID cards(s) for each covered person, reflecting the coverage effective date.

Forms to Use	
Dropping Dependents	Dependent Drop Form
Terminating Plan	If Member gains other coverage–Enrollment Application showing waiver NO HRA
Changing Plans	Enrollment Application
FSA Change	FSA Enrollment/Change Application
Special Notes:	
Signature	The paperwork may be signed by the Employee prior to gaining coverage

QUALIFYING EVENT	DEPENDENT RE-ESTABLISHES PLAN ELIGIBLITY

Health Insurance	Permitted	
Adding Dependent(s) who satisfy plan eligibility requirements	Yes	
Adding Dependent Tag-alongs		No
Change Plan Options if adding a Spouse or Dependent(s)	Yes	
Healthcare FSA	**Permitted**	
Enrolling in or increasing FSA elections	Yes	
Dependent Care FSA	**Permitted**	
Enrolling in or increasing election, if event increases Dependent Care expenses	Yes	
Waiver HRA	**Permitted**	
Does not apply, no change allowed.		No

Event Date	
Adding Spouse/Dependent(s)	Date Dependent re-establishes eligibility

Signature Deadline	35 calendar days from the Qualifying Event date

Effective Date	Cannot be effective before the event date
Adding Spouse or Dependent(s)	First day of the month following the Employee's signature date on the appropriate paperwork
Enrolling or increasing FSA	First day of the month following Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
Adding Dependent(s)	The Employee must provide the reason the Dependent is re-establishing eligibility under the guidelines of KEHP.

Forms to Use	
Adding Dependent(s)	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
FSA Change	FSA Enrollment/Change Application

QUALIFYING EVENT	CHANGE IN RESIDENCE

Health Insurance	Permitted	
Changes NOT allowed		No
Healthcare FSA	**Permitted**	
Changes NOT allowed		No
Dependent Care FSA	**Permitted**	
Increasing or decreasing election if child care provider changes to due change in residence	Yes	
Waiver HRA	**Permitted**	
Does not apply, no change allowed.		No

Event Date	Date residence re-established

Signature Deadline	35 calendar days from the Qualifying Event date.

Effective Date	Cannot be effective before the event date
Dependent Care FSA Increase	First day of the month following Employee's signature date
Dependent Care FSA Decrease	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
	Proof of change in residence

Forms to Use	
Dependent Care FSA	FSA Enrollment/Change Application

QUALIFYING EVENT	LOSS OF GROUP HEALTH INSURANCE THAT ENTITLES EMPLOYEE OR FAMILY MEMBER TO ENROLL UNDER HIPAA SPECIAL ENROLLMENT RIGHTS

Health Insurance	Permitted	
Adding Employee along with Spouse or Dependent(s) including Tag-alongs if event causes loss of coverage under group, individual, "gap" or student health plan.	Yes	
Change Plan Options when adding Dependent or Spouse	Yes	
Healthcare FSA	**Permitted**	
Enrolling in, increasing or decreasing election	Yes	
Dependent Care FSA	**Permitted**	
Enrolling, increasing or decreasing election	Yes	
Waiver HRA	**Permitted**	
Terminate election and redirect the state contribution to Health Insurance	Yes	
Waiver NO HRA	**Permitted**	
Terminating election and waiving Health Insurance with no HRA	Yes	

Event Date	Date of loss of coverage
Signature Deadline	• 35 calendar days from the Qualifying Event date except for Medicaid or KCHIP or KCHIP Premium Supplement • 60 calendar days loss of Medicaid, KCHIP, KCHIP Premium Supplement, or KHIPP The Enrollment application or Dependent Add Form may be signed by the Employee prior to the loss of coverage

Effective Date	Cannot be effective before the event date
Health Plan	First day of the month following Employee's signature date
FSA Increase	First day of the month following Employee's signature date
FSA Decrease	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
Adding Spouse/Dependent(s)	HIPAA Certificate of Creditable Coverage; Letter from Employer on letterhead that includes person(s) covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.
Forms to Use	
Enrolling, Increasing or Decreasing FSA Elections	Enrollment Application or FSA Enrollment/Change Application
Adding Dependents	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Special Notes:	
HIPAA	HIPAA contains protection for both health coverage offered in connection with employment (group health plans) and for individual insurance policies sold by insurance companies (individual policies)
COBRA	Only Expiration of COBRA eligibility is considered a loss of other coverage. The end of a period of employer paid COBRA is not a loss of coverage unless the total COBRA period has been exhausted; this is not a Qualifying Event.

QUALIFYING EVENT	JUDGMENT, DECREE OR ADMINISTRATIVE ORDER RELATING TO HEALTH COVERAGE FOR CHILD (including grandchildren)

Health Insurance	Permitted	
Adding dependent(s) to existing plan if required by a court order, placement papers from Cabinet for Health and Family Services or if legal guardianship has been awarded	Yes	
Adding grandchildren if full legal guardianship or custody has been awarded, or if limited guardianship specifies maintaining health coverage.	Yes	
Adding Employee who previously waived coverage if the court order stipulates to add children to Employee's plan offered through the employer. Upon receipt of an administrative order, the Employee is responsible for full premiums due and may NOT redirect HRA contribution.	Yes	
Drop child if order stipulates that coverage is to be provided by the other parent	Yes	
Change Plan Option if adding Dependents	Yes	
Healthcare FSA	**Permitted**	
Enrolling or increasing election if order requires Employee to provide child's health coverage	Yes	
Dependent Care FSA	**Permitted**	
Enrolling or increasing election if child care expenses increase	Yes	
Waiver HRA	**Permitted**	
Terminating election and redirecting the state contribution to Health Insurance ONLY if a National Medical Support Notice or other employer directed order is received	Yes	

Event Date	Date order or guardianship documents signed by the judge

Signature Deadline	35 calendar days National Medical Support Notice (NMSN) directing employer to enroll in Employee's child in plan, MAY be processed even if the 35 day deadline not met

Effective Date	Cannot be effective before the event date
Adding Dependent at Employee's request	First day of the month following Employee's signature date
Adding Dependent due to NMSN (Employee's consent not needed)	First day of the month following the date of the administrative order or notice
Dropping Dependent due to a new order releasing Employee	Last day of the month in which the child ceases to meet eligibility requirements If dropping a child on NMSN you must have a NMSN rescinding the previous NMSN
Dropping Dependent due to the expiration of an order	Last day of the month in which the child ceases to meet eligibility requirements
Increasing FSA	First day of the month following Employee's signature date
Decreasing FSA	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
Adding Spouse or Dependent(s)	See Dependent Eligibility Chart – Chapter 1, Page 3
Forms to Use	
Enrolling	Enrollment Application
Adding Dependents	Dependent Add Form
Adding Dependent(s) with Plan Option or Coverage Level change	Enrollment Application
Enrolling in or increasing FSA	FSA Enrollment/Change Application
Special Notes:	
Ineligible Dependents	Dropped from the plan at the end of the month of their ineligibility date

QUALIFYING EVENT	EMPLOYEE, SPOUSE or DEPENDENT ENROLLED IN KEHP BECOMES ENTITLED TO MEDICARE (parts A, B or D) or MEDICAID (gaining KCHIP is not a valid QE)

Health Insurance	Permitted	
Dropping Employee, Spouse and/or Dependent(s), if person becomes eligible and enrolled in Medicare or Medicaid	Yes	
Changing Plan Option if dropping Spouse or Dependent	Yes	
Healthcare FSA	**Permitted**	
Enrolling in, or increasing election		No
Decrease election	Yes	
Dependent Care FSA	**Permitted**	
No change allowed		No
Waiver HRA	**Permitted**	
No change allowed		No

Event Date	
	Date the Employee, Spouse or Dependent becomes entitled to Medicare or Medicaid; Medicare may also use the notification date.

Signature Deadline	35 calendar days from event date 60 days from event date for Medicaid

Effective Date	Cannot be effective before the event date
Dropping Employee, Spouse and/or Dependent(s)	Last day of the month in which the QE document was signed
Increasing FSA	First day of the month following Employee's signature date
Decreasing FSA	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
Medicare	Copy of Medicare card (showing effective date) or Initial eligibility letter from Medicare Office
Medicaid	Initial eligibility letter from Medicaid Office or Medicaid Eligibility/Termination Form signed by the Division of Medicaid Services

Forms to Use	
Dropping KEHP coverage	Enrollment Application reflecting a Waiver with NO HRA
Dropping Dependent(s)	Dependent Drop Form may be signed by the Employee prior to the event date; however, the requested change will not be effective prior to the Qualifying Event
Plan Option change	Enrollment Application
Enrolling in or increasing FSA	FSA Enrollment/Change Application
Special Notes:	
KCHIP	Gaining KCHIP is not a valid qualifying event. No changes are allowed
KCHIP Premium Assistance	Is a Qualifying Event to add

QUALIFYING EVENT	BENEFIT OPTION HAS SIGNIFICANT INCREASE OR DECREASE IN COST

Health Insurance	Permitted	
Changes NOT allowed		No
Healthcare FSA	**Permitted**	
Changes NOT allowed		No
Dependent Care FSA	**Permitted**	
Make a corresponding change (increase or decrease). Increasing the election for a day care provider increasing rates mid-year is only permitted if the provider is not a relative of the Employee.	Yes	
Waiver HRA	**Permitted**	
Does not apply, no change allowed.		No

Event Date	Date of rate change

Signature Deadline	35 calendar days from the Qualifying Event date

Effective Date	Cannot be effective before the event date
FSA Increase	First day of the month following Employee's signature date
FSA Decrease	End of the month of the Employee's signature date

Document(s) Required	If Adding, must also submit eligibility verification documents
	Proof of change in rates

Forms to Use	
FSA Dependent Care	FSA Enrollment/Change Application

QUALIFYING EVENT	EMPLOYEE, RETIREE OR SPOUSE HAS A DIFFERENT OPEN ENROLLMENT PERIOD (includes military insurance coverage, except for veterans administration benefits)

Health Insurance	Permitted	
Adding Employee, Spouse or Dependent(s) if Employee, Spouse or Retiree dropped coverage during the Open Enrollment period	Yes	
Dropping Employee, Spouse or Dependent(s)if Employee, Spouse or Retiree enrolled family during the Open Enrollment period	Yes	
Healthcare FSA	**Permitted**	
After KEHP Open Enrollment and before January 1: Employees may make changes corresponding to change made under other employer's plan or military plan.	Yes	
After 12/31 no change allowed		No
Dependent Care FSA	**Permitted**	
Make a corresponding change (increase or decrease). Increasing the election for a day care provider increasing rates mid-year is only permitted if the provider is not a relative of the Employee.	Yes	
Waiver HRA	**Permitted**	
After KEHP Open Enrollment and before January 1: Employee may make corresponding changes and redirection of state contribution is allowed	Yes	
After 12/31: Employee may make corresponding change. (No redirection permitted)	Yes	

Event Date	Last day of the Employee's, Retiree's or Spouse's Open Enrollment Period

Signature Deadline	35 calendar days from the Qualifying Event date

Effective Date	Cannot be effective before the event date
Adding or dropping Dependent(s)	Same as the Effective Date of the Employee, Retiree's or Spouse's plan

Document(s) Required	If Adding, must also submit eligibility verification documents
	Letter from employer on employer's letterhead, identifying Open Enrollment period and deadline Effective Date of plan Persons being added or dropped from the policy

Forms to Use	
Enrolling	Enrollment Application
Adding Dependents	Dependent Add Form
Requesting Plan Option Change	Enrollment Application
Dropping Dependents	Dependent Drop Form
FSA Changes	FSA Enrollment/Change Form

CHAPTER 5A

AUTOMATIC LOSS OF COVERAGE

1. Automatic Loss of Coverage

Certain incidents may result in an Automatic Loss of Coverage, with or without the occurrence of a corresponding Qualifying Event. When an Automatic Loss of Coverage takes place, the occurrence of a Qualifying Event is not necessary to justify the cessation of coverage. The Employee's initial election for coverage already encompassed the concept of automatic revocation, so a mid-year "change" in election is not needed.

A. Examples of Incidents Resulting in Automatic Loss of Coverage

- An incident such as death, loss of employment status, or loss of dependent status which causes an Employee, Retiree, Dependent or Beneficiary to lose eligibility under the Eligibility Requirements of Kentucky Revised Statute 18A.225
- An incident such as death, divorce, loss of employment status, or loss of dependent status which causes an Employee, Retiree or Beneficiary to lose eligibility for the Cross-Reference Payment Option (refer to Chapter 3 for more information on the Cross-Reference Payment Option)
- Incarceration (notice of incarceration must be provided to the Enrollment Information Branch)
- Moving to Another Country (coverage while out of the country is specifically excluded except for emergencies)

B. Termination of Coverage due to an Automatic Loss of Coverage

If an incident triggers an Automatic Loss of Coverage, the Enrollment Information Branch will determine the coverage termination date. This will typically be either:

- the 1st day of the month following the actual date of the incident resulting in the Automatic Loss of Coverage; or
- the 1st day of the month following the date the Enrollment Information Branch receives notice of the incident resulting in the Automatic Loss of Coverage.

If the incident is discovered after-the-fact and coverage is retroactively terminated, any refunds of Employee contribution(s) should be made on an "after-tax" basis.

C. Re-gaining Eligibility for Coverage

In the event of a change in the circumstances which resulted in an Automatic Loss of Coverage, the planholder or former planholder may re-apply for coverage via the normal application procedures.

CHAPTER 6:

BOARDS OF EDUCATION

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“Year Round” Employees (All Other Boards of Education Staff)	Page 2

1. Boards of Education Termination of Coverage

School district Employees who work under a July 1st through June 30th contract will be allowed to retain KEHP coverage through August 31st provided the:

- terms of their contract are fulfilled and
- premiums for their summer KEHP coverage are deducted from the last paycheck(s).

At the end of the contract, if the Employee is non-renewed or the district has issued a "pink slip" with the intention of re-hiring the Employee in the fall, the same coverage extension rules apply. This information should be sent to KEHP on an Update Form or the Pink Slip Form which are both on KEHP's website at www.kehp.ky.gov.

The employment end date will be the 6/30 contract end date and the insurance termination date will be the last day of the month their coverage is paid for, i.e. 7/31 or 8/31.

If July and/or August premiums are not deducted from the last paycheck(s) but the Employees have fulfilled the terms of their contract, coverage will end on the last day of the semi-monthly period for which premiums were paid in full. On the Update Form, the employment end date will be the 6/30 contract end date and the insurance termination date will be the last day of the semi-monthly period for which premiums were paid in full.

A. Retirements

Employees who retire at the end of their contract, coverage will end on June 30 and all premiums for June are due from the district. Retirement will pick up coverage according to their rules which generally means a July 1 coverage effective date. However, final determination of when retirement coverage begins is subject to the rules of that retirement system. The retirement system, like all other agencies, is responsible for processing this in a timely manner to ensure proper coverage. On the Update Form, please indicate a 6/30 end date for both employment and coverage and write "Retirement" on the form.

B. Terminations Before Contract Ends

Employees who stop working before the last contract day; or, who fail to fulfill the terms of their employment contract; should be terminated from coverage following the regular employment termination rules indicated below. This information should be communicated to KEHP on an Update Form.

Employment stops between 1st and 15th :
•Health Insurance ends on 15th of same month
•FSA/HRA end on last day of work

Employment stops between 16th and 31st:
•Health Insurance ends on last day of same month
•FSA/HRA end on last day of work

These rules above apply to the following plans:
-Health Insurance
-Flexible Spending Accounts (FSAs)
-Health Reimbursement Accounts (HRAs)

Employees whose Health Insurance premiums or Waiver HRA contributions are fully paid by the Employer and who qualify for the extended summer coverage will be allowed to retain their coverage.

2. Summer Transfers

School district Employees who work the last day of their contract under the old school district and the 1st of their contract under the new school district are classified as "Summer Transfers."

The old district that is losing the Employee should follow the information in "Section A" above. Coverage will be extended through the summer if the Employee worked the last day of the contract and premiums are paid. If both Summer Transfer contract date rules are fulfilled and summer premiums have been received, the Employee will not experience a break in coverage. Coverage under the old district will terminate on August 31 and coverage under the new district will begin on September 1. When notifying KEHP of a summer transfer, please write "Summer Transfer" on the Update Form or the Enrollment Application.

Employees who should have been classified as a "Summer Transfer but for whom premiums were not deducted for the summer months will likely experience a break-in-coverage. If this occurs, Employees have two options. The same options also apply to Employees whose new school district did not realize they were a summer transfer and as a result, the Employees experience a break in coverage when the new hire "1st day of the 2nd month" waiting period was applied.

Employees may choose:

- to back up coverage as early as their hire date under the new school district and pay the arrears either by personal check or through their first paycheck; or
- to leave the summer months without KEHP coverage due to lack of medical or pharmacy claims, and begin coverage either on August 1st or September 1st. *Please know if the break in KEHP is more than 63 days, pre-existing condition rules will be applied to claims.*

When notifying KEHP of an Employee who should have been classified as a summer transfer instead of a new hire, please write "CORRECTION: Summer Transfer" on the Update Form or the Enrollment Application and indicate the Effective Date of their coverage based on the options above. The three Effective Date possibilities are

- the hire date
- August 1st or
- September 1st

If the contract employment date rules were not fulfilled, the Employees are not considered a summer transfer and must enroll as a new Employee in the fall, subject to all new employment rules and deadlines.

Summer transfer and coverage terminations must be submitted within 10 Days of the occurrence.

Employees whose Health Insurance premiums or Waiver HRA contributions are fully paid by the Employer and who qualify for the extended summer coverage will be allowed to retain their coverage.

3. "Year Round" Employees (all other Board of Education staff)

Year Round Employees will be processed in the same manner as a 12-month Employee transferring during any other time of the year.

CHAPTER 7:

FLEXIBLE BENEFITS

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Flexible Benefits

The KEHP Flexible Benefits program is provided through a Section 125 Cafeteria plan and allows participating Employees to pay for eligible healthcare and Dependent care expenses with pre-tax dollars. KEHP currently offers the following Flexible Benefits to all Eligible Employees whose agencies participate in KEHP's Flexible Benefits program:

- Healthcare Flexible Spending Account;
- Dependent Care Flexible Spending Account; and
- Health Reimbursement Account (HRA)

Eligible Employees who wish to participate in any of the Flexible Benefit programs MUST enroll online in KHRIS or complete a paper Enrollment Application EVERY YEAR during the annual Open Enrollment period. Enrollment is NOT automatic and enrollment elections WILL NOT carry-over to the next Plan Year. Section 125 plans are federally regulated and changes are not permitted outside of the annual Open Enrollment period unless Employees experience an appropriate Qualifying Event as outlined in Chapter 5.

1. Eligibility Requirements

Active Employees who are eligible for the state sponsored Health Insurance coverage may enroll in a Healthcare FSA or a Dependent Care FSA during Open Enrollment, or as a result of an applicable Qualifying Event.

Employees may enroll in either FSA program within 35 days of their employment date or 35 days of their eligibility for benefits date. The Effective Date will be the first day of the second month from the date of hire (i.e. Employee hire date is February 25; Employee's Effective Date would be April 1). Quasi-Governmental Agencies will have a different effective date. Indicate the Effective Date on the Enrollment Application and adjust the number of semi-monthly pay periods.

Employees who are eligible for state-sponsored Health Insurance coverage but elect to waive such coverage will be eligible for the Waiver HRA with an employer contribution up to a maximum of $2,100 per Plan Year, provided the employer participates in KEHP Flexible Benefits. The Employee may not contribute any money to this account.

Employees who are eligible for the state-sponsored Health Insurance coverage and who elect to enroll in the Commonwealth Maximum Choice Plan are eligible for the HRA that is embedded in the Health Insurance plan. The HRA employer contribution amount for the Commonwealth Maximum Choice Plan will be:

- $1,000 Single Coverage Level
- $1,500 Parent Plus Coverage Level
- $1,500 Couple Coverage Level
- $2,000 Family Coverage Level

NOTE: Employees who currently have a Health Savings Account (HSA) with their Spouse's employer may NOT be eligible to have an HRA with KEHP due to IRS guidelines, which govern cafeteria plans.

NOTE: Active Employees who are covered Spouses on a hazardous duty Retiree's plan will not be eligible to direct the state contribution into an HRA. Retirees, who return to work, are eligible to participate in the FSA programs. Retirees who return to work are eligible to participate in any Health Insurance plan and the Waiver HRA, if they waive coverage through their respective retirement system.

2. Redirection of the Employer Contribution

Redirection is the ability of an Employee to stop employer funds from going into a stand-alone HRA in order to start receiving an employer contribution toward a Health Insurance plan as a result of experiencing a permitted Qualifying Event. There are NO Qualifying Events that allow an Employee to stop a Health Insurance plan to enroll in a waiver with a stand-alone HRA, except returning from Military Leave.

3. Contribution Amounts

A. Healthcare FSA

- The maximum allowable yearly contribution is $5,000.

B. Dependent Care FSA

The maximum yearly contribution amount depends on the Employee's tax filing status as listed below:

- married filing separately $2,500
- single and head of household $5,000
- married and filing jointly $5,000

C. Waiver HRA

Employees who waive their Health Insurance coverage, if eligible, receive $2,100 annually from their employer into a Waiver HRA. The maximum annual contribution is $2,100.

If Employees terminate coverage any time during the Plan Year and are rehired during the same Plan Year, the employee continues to remain eligible to receive the monthly $175 per month contribution to use on claims, provided the contribution amount was not spent on claims prior to terminating. The company continues to remain responsible for submitting the monthly contribution to KEHP.

Example: An Employee waives coverage January 1 and terminates coverage (and HRA) on May 31. The Employee would have access to the $2,100 for any expenses incurred between January 1 and May 31. The Employee is later re-hired in August for an October 1 effective date. The Employee **will NOT** receive additional funds of $175 for October, November and December if the entire $2100 was spent before termination. However, the company must still pay the monthly contributions to KEHP for these months.

If the Employee has funds remaining in the account at the time of termination (May 31), the funds will be available for the remaining months (October – December).

Employees who have the HRA with the Commonwealth Maximum Choice Plan receive the amount as indicated in the Benefits Selection Guide and page 1 of this Chapter.

4. Termination of Flexible Benefits

Healthcare and Dependent Care Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs) end on the same day an Employee terminates employment, regardless of when that occurs.

Example: An Employee terminates employment on March 5. Eligibility for FSA and HRA funds terminates on March 5. The Employee can request reimbursement for healthcare or Dependent care funds spent up to March 5, but cannot incur new claims after March 5.

5. Billing Period and Payment Due Reference Chart

Effective Date	Bill Period		Payment Due
January 1	1/1	1/15	1/15
	1/16	1/31	1/30
February 1	2/1	2/15	2/15
	2/16	2/28	2/28
March 1	3/1	3/15	3/15
	3/16	3/31	3/30
April 1	4/1	4/15	4/15
	4/16	4/30	4/30
May 1	5/1	5/15	5/15
	5/16	5/31	5/30
June 1	6/1	6/15	6/15
	6/16	6/30	6/30
July 1	7/1	7/15	7/15
	7/16	7/31	7/30
August 1	8/1	8/15	8/15
	8/16	8/31	8/30
September 1	9/1	9/15	9/15
	9/16	9/30	9/30
October 1	10/1	10/15	10/15
	10/16	10/30	10/30
November 1	11/1	11/15	11/15
	11/16	11/30	11/30
December 1	12/1	12/15	12/15
	12/16	12/31	12/31

6. Time Limit for Refund Requests for FSA/HRA Contributions

A refund of FSA/HRA contributions will only be given for up to 60 days from the end of the semi-monthly period in which the Qualifying Event occurred. The exception to this rule is the Qualifying Event of death, in which the HRA contributions are eligible to be refunded back to the first day of the Plan Year (if necessary).

Example:

- Qualifying Event is on May 5
- Update Form is received on October 7
- End of the semi-monthly period from the QE is May 15; therefore a refund will be given for the semi-monthly periods of May 16 – May 30; June 1 –June 15, June 16-June 30 and July 1- July 15.

Example:

- Qualifying Event of death is on May 5
- Update Form is received on October 7
- End of the semi-monthly pay period from the QE is May 15; therefore a refund will be given for the semi-monthly periods of May 16 – May 30; June 1 –June 15, June 16-June 30 and July 1- July 15, July 16-July 31, August 1-August15, August 16 – August 31, September 1 – September 15, September 16 - September 30, and October 1-October 15.

7. Leaves of Absence

A. Leave Without Pay (LWOP)

1. Beginning LWOP

Employees on LWOP must work at least one day during each semi-monthly pay period to be eligible to receive the HRA employer contribution.

Example: If the Employee waives coverage and has the waiver HRA, and the Employee works one day from the 1st through the 15th, the Employee will be eligible to receive ½ of the employer contribution ($87.50) for that pay period.

If the Employee works one day from the 16th to the end of the month, the Employee will receive ½ of the employer contribution ($87.50) for that period.

Non-Commonwealth Paid contributions are due on the 15th and Commonwealth Paid contributions are due on the 5th of the month in which leave begins.

The Insurance Coordinator must collect the check for the contributions (payable to the Kentucky State Treasurer) and forward it to:

Financial Management Branch
Flexible Spending
Department of Employee Insurance
Personnel Cabinet
501 High Street, 2nd Floor
Frankfort, Kentucky 40601

If an Employee is on approved LWOP, the waiver HRA, Healthcare and Dependent Care FSA <u>will terminate the last day worked</u>. The Insurance Coordinator must enter the "end participation LWOP action" and terminate benefits in KHRIS, or submit a FSA Enrollment/Change Application reflecting the approved LWOP begin date.

Employees who lose the Waiver HRA or Healthcare FSA because they did not work at least one day during a semi-monthly period must be entered into Ceridian's WebQE system to receive COBRA information. Dependent Care FSA is not eligible for COBRA.

2. Returning from LWOP

Employees who return to work after being on approved LWOP will become effective either the 1st or the 16th of the month. Employees who return to work after being on LWOP will be reinstated to the same elections he/she had prior to LWOP status, unless they have experienced a Qualifying Event that would allow a change.

Example: if the Employee returns from approved LWOP between the 1st and the 15th of the month, the FSA is reinstated on the 16th day of the same month and KEHP expects both ½ month payments.

Employee returns from approved LWOP between 16th and the last day of the month, FSA is reinstated on the first of the following month and KEHP expects a full month payment for that month.

This only applies to Healthcare FSAs. The stand-alone Waiver HRA and the Commonwealth Maximum Choice embedded HRA may be processed differently since the HRA is employer money and subject to the employer's LWOP rules.

B. Family Medical Leave Act (FMLA)

When Employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave letter in Appendix E.

1. Beginning FMLA

FMLA leave is not a Qualifying Event to make any changes to the Healthcare FSA. When Employees begin paid or unpaid FMLA, the employer contribution for the HRA will continue until FMLA expires. The Employees are responsible for their Healthcare Flexible Spending Account. The Employees may choose to:

- Cease contributions (terminate the entire contribution);
- Prepay the total contribution for the FMLA leave period;
- Choose the pay-as-you-go method. (If the Employees choose this method of payment the Employee's contribution are due at the same time the contribution would be made by payroll deduction).

When Employees are on FMLA, the Insurance Coordinator should collect the FSA check (payable to the Kentucky State Treasurer) and forward contribution checks to:

Personnel Cabinet
Department of Employee Insurance
Financial Management Branch
501 High Street, 2nd Floor
Frankfort, Kentucky 40601

2. Returning from FMLA Leave

If elections continued during FMLA, the elections continue with no change when the Employee returns from FMLA.

Employees may choose one of the following for their FSA:

- Proration: Employees may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed
- Pay in advance of their leave

3. Not returning from FMLA Leave

When Employees have exhausted their FMLA leave, and do not return to work (begin LWOP), the Insurance Coordinator must notify the Employees of their COBRA rights, regardless of the Employee's FSA status during the FMLA.

For purposes of COBRA, the date of the COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for COBRA through the end of the Plan Year

C. Military leave

Employees may discontinue their contributions to the Flexible Spending Account Program when they are activated with the Armed Services. This option will allow the Employees to be reinstated when returning to employment from military leave.

Employees may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed.

Employees returning between the 1st and the 15th of the month will be effective on their date of return BUT will have to pay the entire Employee's monthly contribution for FSA. The employer will be required to pay HRA contributions for the monthly period in which the Employee returns.

Employees returning on or after the 16th of the month will be effective on their date of return BUT will only need to pay ½ of the election for FSA. The employer will be required to pay the employer's portion of the contribution for HRA for the semi-monthly period in which the Employees return.

7. Claims Payment

A. Paper Claims

Healthcare FSA, Dependent Care FSA and Health Reimbursement Account (HRA) paper claims can be submitted to Humana by completing a Health Reimbursement Account and Spending Account Reimbursement Claim Form. This form is located on KEHP's website. The form and all supporting documentation should be

Mailed to:

Humana Spending Account Administration
PO Box 14167
Lexington, KY 40512-4167; or

Customer Service: 800-604-6228/800-905-1851 FAX

The Employee should include with your claim form a written statement from an independent third party (e.g., a receipt, EOB, etc.) or a letter of medical necessity associated with each expense that indicates the following:

- The nature of the expense (e.g. what type of service or treatment was provided).
- If the expense is for a prescribed over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

Humana will process the claim(s) once all information is received. If claims are eligible you will receive reimbursement. If the claim is not an eligible expense you will receive notification.

All claims must be submitted for reimbursement during the Plan Year in which they were incurred or during the Run - Out Period which extends to March 31 of the next year.

B. Electronic Claims Payment

Healthcare FSA, Health Reimbursement Account (HRA) claims and Commonwealth Maximum Choice plan claims can be processed electronically using the Humana*Access VISA* Card (HAC). The HAC is not available for use with the Dependent Care FSA.

Members may use the HAC at the time they receive a covered service by simply swiping the HAC just like they are making a purchase. There is no PIN provided with the HAC; therefore, select "credit" at the time of purchase. Humana*Access* VISA Cards are issued for multiple years, and are not reissued every Plan Year. If Employees have funds in their account, the HAC card will continue to work from year to year. Employees must activate the HAC prior to using.

The HAC will be turned off when employment or coverage terminates. Also, the card will be turned off if the Employee fails to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) within thirty (30) days after the swipe the Humana*Access* VISA Card, then Humana will request this substantiation. If substantiation is not received within 30 more days (for a total of 60 days from the initial Humana*Access* Card swipe), then claims processing will be suspended. This suspension of claims will include the use of the Humana*Access* Card as well as reimbursements for traditional paper claims. Substantiation for all claims must be received before the HAC will be reactivated, or before paper claims will be processed.

KEHP reserves the right to initiate the following correction procedures to recoup money from Members for claims that are improperly paid from the Healthcare FSA or HRA.

- Deny Access to the Humana*Access* Card to ensure that no further violations occur. The Humana*Access* Card will be deactivated until the amount of the improper claim payment is recovered.
- Require Repayment. The employer may "demand" that the Employee repay the improper payment. A letter to the Member will be sent identifying the amount, the reasons for requiring repayment, and the timeframe in which the repayment must be made.
- Withhold From Pay. If the demand for repayment is unsuccessful, then an amount equal to the improper payment must be withheld from the participant's pay or other compensation, to the full extent permitted under applicable law.
- Offset. If the improper payment is still outstanding and amounts are not available to be withheld, then the employer is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment.
- Treat Payment as Other Business Indebtedness. If the above correction efforts prove unsuccessful, then the Employee remains indebted to the employer for the amount of the improper payment. In that event, and consistent with its business practices, the employer may treat the payment as it would treat any other business indebtedness.

Refer to the specific Summary Plan Description on KEHP website for further details on the Humana*Access* VISA Card and the substantiation requirements.

9. Timely Filing of Claims

All claims must be submitted by March 31st of the following Plan Year. Services will not be covered unless the Employees are eligible for benefits on the date services are rendered. *Example*: Employees who have coverage from 1/1 - 5/31, may submit claims for reimbursement up to 3/31 of the next calendar year, provided the *dates of service* of such claims are between 1/1 - 5/31.

10. Termination for Non-Payment of FSA and HRA Contributions

If a member's FSA/HRA contributions are not received by their company, coverage will be terminated as follows:

Semi-Monthly Basis

- If contributions are not received for one semi-monthly period then the Insurance Coordinator will receive notification via fax or email, that coverage may be terminated and if so, any claims paid by Humana will need to be refunded by the Employee.
- If contributions are not received for two semi-monthly periods, then the Insurance Coordinator as well as your Employee will receive notification via fax or email, that coverage may be terminated and if so, any claims paid by Humana will need to be refunded by the Employee.
- If contributions are not received for four semi-monthly periods, then coverage will be terminated on the last day of the semi-monthly period in which contributions were received. ***The Insurance Coordinator and the Employee will receive notification via US Mail advising of the termination date, as well as whether or not any claims have been processed by Humana since termination. Your Employee will be responsible for refunding any claims that Humana has processed.***

Monthly Basis

- If contributions are not received for one monthly period, then the Insurance Coordinator will receive notification via fax or email, that coverage may be terminated and if so, any claims paid by Humana will need to be refunded by the Employee.
- If contributions are not received for two monthly periods, then coverage will be terminated on the last day of the monthly period in which contributions were received. The Insurance Coordinator and the Employee will receive notification via US Mail advising you of the termination date, as well as whether or not any claims have been processed by Humana since termination. Your Employee will be responsible for refunding any claims that Humana has processed.

CHAPTER 8:

GRIEVANCES AND APPEALS

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1. Grievance Process for Eligibility and Enrollment Issues

Employees who are dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Plan may file a grievance to the KEHP Grievance Committee. The grievance must be filed no later than thirty (30) calendar days from the event or notice of the decision being protested. Grievances must be filed in writing to:

Personnel Cabinet
Department of Employee Insurance
Attention: Eligibility and Enrollment Grievance Committee
501 High Street, Second Floor
Frankfort, KY 40601

A grievance must include ALL of the following: 1) Name, social security number and company where employed; 2) A description of the issue(s) disputed; 3) A statement of the resolution requested; 4) All other relevant information; and all supporting documentation.

Any grievance that does not include all necessary information will be returned. A written response will be mailed to the Employee and the Insurance Coordinator stating the decision of the Committee. The Committee will review a second request only if additional relevant facts are provided.

2. Appeals to Humana (Third Party Administrator)

Humana has a two-level internal appeal process for appeals relating to medical claims. Refer to the relevant Health Insurance Summary Plan Description for details.

3. Appeals to Express Scripts, Inc. (Pharmacy Benefit Manager)

Express Scripts, Inc (ESI) has a one-level internal appeals process for pharmacy claims. Refer to the relevant pharmacy Summary Plan Description for details.

4. External Review for Appeals to Humana and Express Scripts

If an Employee has exhausted all levels of internal appeals with Humana and/or Express Scripts and desire to appeal further, he/she may request an external review through the Kentucky Department of Insurance. Refer to the relevant medical or pharmacy Summary Plan Description for details.

5. Prescription Formulary Appeals

Employees who are dissatisfied with a change in the prescription formulary may file an appeal to the Kentucky Employees' Health Plan Administrative Appeals Committee. The appeal must be filed no later than 60 days from the date of the notice of the formulary change. Appeals must be filed in writing to:

Personnel Cabinet
Department of Employee Insurance
Kentucky Employees' Health Plan
Attention: Administrative Appeals Committee
501 High Street, Second Floor
Frankfort, KY 40601

The Appeal must include ALL of the following: 1) Name, social security number and company where you are employed; 2) A description of the formulary change being disputed; 3) A physician's statement which states that in the opinion of the physician, the Member should continue taking the drug as before the formulary change; 4) All other relevant information; and 5) All supporting documentation.

CHAPTER 9:

HIPAA

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HIPAA

The Health Insurance Portability and Accountability Act was passed by Congress in 1996. This law helps to protect an Employee's right to health coverage during events such as changing or losing jobs, pregnancy, moving or divorce. It also provides rights and protections for employers when obtaining and renewing health coverage for their Employees.

The HIPAA's Privacy Rules became effective April 14, 2003. These were issued to provide protection against the unauthorized use and disclosure of an individual's Protected Health Information (PHI). KEHP is adhering to these rules in order to protect the confidentiality of our members. PHI is defined as information that can be identified as belonging to a specific individual. This information can be transmitted or maintained in many ways such as, but not limited to, mail, fax, copier, telephone, email or paper mediums. Disclosure of PHI to anyone other than the Member is prohibited without the member's specific authorization to disclose.

Health Insurance and Healthcare Flexible Spending Account information maintained by the KEHP may be disclosed to the member's Spouse, Dependent, or the member's legal counsel/representative if that Member has completed an Authorization for Disclosure form for the Plan Year and it has been received by KEHP. If the Member obtains legal counsel, the Member will need to complete the Authorization for Disclosure form and also provide a copy of the Letter of Representation authorizing KEHP to correspond with the legal counsel. If the correct information is not provided to KEHP, there will be no disclosure of information to anyone except the member. The KEHP only maintains demographic information on members. KEHP will only provide information pertaining to eligibility, enrollment, disenrollment and Qualifying Events.

Authorization for Disclosure forms are maintained by KEHP for the Plan Year or until revoked by the member, whichever is shorter. KEHP's HIPAA Privacy Notice and Authorization form are located online at www.kehp.ky.gov.

1. KEHP and HIPAA

Due to compliance requirements, KEHP implemented several changes designed to protect personal health information used in electronic mail. These changes are applicable to all programs. When a member's information is being transmitted via electronic mail there are two competing interests: (1) the Planholder has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) the Employees involved in the communication have an interest in sharing the maximum amount of information permissible to ensure the purpose/needs of the communication is/are met. KEHP does not maintain information regarding Employee's specific medical or health conditions but does maintain demographic PHI and other information that is necessary for determining eligibility and enrollment in KEHP.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of KEHP's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request. Based on these concerns, KEHP implemented the following procedures for transmitting Employee information (PHI or personally identifiable information) to our vendors/third-party administrators (TPA), Insurance Coordinators, Enrollment Specialists, Business Associates, and Billing Specialists within KEHP via electronic mail: Use encrypted email (ENTRUST or a similar encryption product) to transmit any and all PHI. In the subject line of the encrypted email use the word "Confidential."

Using the word "Confidential" in the subject line ensures that the Commonwealth Office of Technology (COT) can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would include any electronic mail marked *confidential*, the request will be forwarded to KEHP so that the requested electronic mail may be edited before complying. If your company does not use any encryption software and you need to communicate an Employee's information to KEHP you must fax the

information (using a cover sheet that identifies the information as "*confidential health information").* DO NOT send any PHI information via email if you do not have encryption software. When KEHP faxes information to an Insurance Coordinator they will first call to verify the Insurance Coordinator is available to receive the fax. After receiving the fax the Insurance Coordinator must call KEHP to acknowledge receipt of the fax.

Members will need to contact their TPA/PBM for information relating to payment of claims and which benefits are covered under their health plan. If the Member needs to have information disclosed from the TPA/PBM to someone other than themselves, the TPA/PBM may require them to complete an Authorization for Disclosure form. KEHP's Authorization for Disclosure Form will not be accepted by the TPA/PBM. The Member will be required to abide by the TPA/PBM's policies and procedures concerning release of their PHI.

2. ENTRUST Software

ENTRUST is available to all Insurance Coordinators within KEHP **free of charge**. There are two different appliances that may be installed depending upon whether your email domain is managed by COT (Commonwealth Office of Technology).

If your e-mail is managed by COT, you can get ENTRUST installed on your computer. This will be integrated directly into your Outlook and will allow you to send and receive encrypted e-mails directly from Outlook. All requests for ENTRUST installation are to go through your IT support department, who in turn, will coordinate the necessary processes with the COT Support Desk. Once installed, this will allow you to send and receive encrypted e-mails. There is no charge for this additional service.

If your e-mail is not managed by COT, you can get ENTRUST installed on your computer. This will allow you to send and receive encrypted e-mails through a web interface and receive alerts in Outlook when you have messages waiting for you. This web appliance is free.

If you already have ENTRUST but do not remember your password, please contact COT Support Desk at 502-564-7576 to have your password reset. If you do not have ENTRUST, you may register directly at https://securemail.ky.gov/webmail/do/Start.

3. Training

KEHP requires annual HIPAA training for Insurance Coordinators and Employees within the Department of Employee Insurance. Training is online through KY TRAIN. Learn how to register for training by accessing the following link http://personnel.ky.gov/dei/10planyear/inscoord.htm and click on "How to Register for a Course on KY TRAIN". KEHP's HIPAA training module number is 1019274.

4. HIPAA Forms and Contact Information

KEHP's HIPAA Privacy Notice, Privacy and Security policies, and Authorization Form are located online at http://personnel.ky.gov/dei/hipaa.htm. Contact Information:

HIPAA Privacy Officer**:** Joe R. Cowles, (502) 564-7430

HIPAA Security Officer: Cindy Stivers, (502) 564-6730

CHAPTER 10:

COBRA

Consolidated Omnibus Budget Reconciliation Act

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COBRA Continuation of Benefits

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more Employees. The law requires that employers offer Employees and/or their Dependents continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

1. Eligibility

A Qualified Beneficiary under COBRA law means an Employee, Employee's Spouse or Dependent child covered by the Plan on the day before a Qualifying Event. A Qualified Beneficiary under COBRA law also includes a child born to the Employee during the coverage period or a child placed for adoption with the Employee during the coverage period.

Employees covered by KEHP have the right to elect COBRA continuation coverage if coverage is lost due to one of the following Qualifying Events:

- Termination (for reasons other than gross misconduct) of the Employee's employment or reduction in the hours of Employee's employment; or
- Termination of Retiree coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

Spouses covered by KEHP have the right to elect continuation coverage if the group coverage is lost due to one of the following Qualifying Events:

- The death of the Employee;
- Termination of the Employee's employment (for reasons other than gross misconduct) or reduction of the Employee's hours of employment with the employer;
- Divorce or legal separation from the Employee;
- The Employee becomes entitled to Medicare benefits; or
- Termination of a Retiree Spouse's coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

Dependent Children covered by KEHP have the right to continuation coverage if group coverage is lost due to one of the following Qualifying Events:

- The death of the Employee-parent;
- The termination of the Employee-parent's employment (for reasons other than gross misconduct) or reduction in the Employee-parent's hours of employment with the employer;
- The Employee-parent's divorce or legal separation;
- Ceasing to be a "Dependent child" under the Plan;
- The Employee-parent becomes entitled to Medicare benefits; or
- Termination of the Retiree-parent's coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

2. Loss of Coverage

A loss of coverage is when coverage is lost in connection with the above Qualifying Events, when a covered Employee, Spouse or Dependent child ceases to be covered under the KEHP terms and conditions as in effect

immediately before the Qualifying Event (such as an increase in the premium or contribution that must be paid for Employee, Spouse or Dependent child coverage).

If coverage is reduced or eliminated in anticipation of an event (example: an employer eliminating an Employee's coverage in anticipation of the termination of the Employee's employment, or an Employee eliminating the coverage of the Employee's Spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

3. Maximum Coverage Period

COBRA continuation coverage may continue up to:

- Employee's employment or reduction in hours of employment;
- 36 months for a Spouse whose coverage ended due to the death of the Employee or Retiree, divorce, or the Employee becoming entitled to Medicare at the time of the initial qualifying event;
- 36 months for a Dependent child whose coverage ended due to the divorce of the Employee parent, the Employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the Employee, or the child ceasing to be a Dependent under the Plan;
- For the Retiree, until the date of death of the Retiree who is on continuation due to loss of coverage within one year before or one year after the employer filed Chapter 11 bankruptcy.

4. Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. The Qualified Beneficiary must provide notice of such determination prior to the end of the initial 18 month continuation period to be entitled to the additional 11-months of coverage. Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a Qualified Beneficiary is determined by SSA to no longer be disabled, he/she must notify the Plan of that fact within 30 days after SSA's determination.

5. Second Qualifying Event

An 18-month extension of coverage will be available to Spouses and Dependent children who elect continuation coverage if a second Qualifying Event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second occurs is 36 months. Such second Qualifying Event may include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. The Employees must notify the Plan within 60 days after the second Qualifying Event occurs if they want to extend your continuation coverage.

6. COBRA Administrator

Humana, the KEHP's Third Party Administrator (TPA), has partnered with Ceridian COBRA Continuation Services to administer COBRA for KEHP members. Ceridian uses an on-line enrollment system called WebQE as the method for COBRA notification. As the Insurance Coordinator, you must enter your Employee's new hire and COBRA Qualifying Event information via the Internet based WebQE system. Ceridian will be responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

7. Notification of COBRA Rights – Initial Notice/General Notice

Insurance Coordinator's must enter all new hire information and COBRA Qualifying Event information in Ceridian's WebQE system. COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to all covered Employees and their Spouses, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice. This Initial Notice or General Notice will be mailed to Employees by Ceridian COBRA Continuation Services immediately after the Insurance Coordinator enters the Employee's new hire information or COBRA Qualifying Event information on Ceridian's WebQE.

8. Notification of a Qualifying Event

The employer cannot detect the occurrence of some Qualifying Events, because information concerning such events is uniquely within the control of the Qualified Beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered Employee or other Qualified Beneficiary notify the Insurance Coordinator of the following events:

- Divorce or legal separation;
- Dependent children ceasing to qualify as Dependents under the terms of the plan;
- The occurrence of a second Qualifying Event after the Qualified Beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29 months; and
- A determination by the Social Security Administration (SSA) that a covered Employee or other Qualified Beneficiary is disabled or a subsequent determination by the SSA that the individual is no longer disabled.

The Employees or their qualified beneficiaries are required to notify you no later than 60 days after the Qualifying Event. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for the affected individuals. The employer must notify the Employees of some Qualifying Events. <u>If the event results in a loss of coverage under the group health plan, the Insurance Coordinator must notify the covered Employees and their Spouses and Dependent children of their COBRA rights for the following events</u>:

- Death of the covered Employee;
- Termination of employment (other than for gross misconduct);
- Reduction in the Employee's hours of employment;
- The Employee's entitlement to Medicare (under Parts A or B, or both);
- The employer's bankruptcy; and
- Break in coverage due to a transfer between agencies within the KEHP.

When Employees experience any of the above Qualifying Events, the Insurance Coordinator must enter all necessary information in Ceridian's WebQE system. Ceridian will then mail all necessary notifications and forms within the required timeframes.

9. COBRA Rates

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge Employees 100 percent of the cost of the group health coverage, plus an additional two percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix G) and the KEHP Web site. The additional two percent covers the added cost for administering COBRA continuation coverage.

CHAPTER 11:

NEW EMPLOYEE ORIENTATION

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New Employee Orientation

This Chapter has been designed to assist Insurance Coordinators with the enrollment of new Employees. All new Employees should receive the following information:

1. Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women's Health and Cancer Rights Act

Federal law requires that all Employees receive notification of the Notice of Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act. A copy of this notice is provided for your assistance in Appendix B.

2. KEHP Checklist

New Employees should be given the KEHP checklist for review and they should check each item as explained to them by the Insurance Coordinator. This checklist ensures that Employees have received the required information and protects the Insurance Coordinator in the event of a discrepancy. A KEHP checklist is included in Appendix C and should be made a part of the employee's personnel files as acknowledgement of receipt of information.

3. Additional Resources

Employees should visit the KEHP website at www.kehp.ky.gov to locate the Benefits Selection Guide and the Summary Plan Descriptions. Both documents will provide necessary information in making their benefit selections.

CHAPTER 12:

BENEFITS ACCOUNTING

COLLECTIONS & DISBURSEMENTS

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Throughout Chapter 12 there is reference to Health Insurance, Life Insurance, FSA and HRA bills. Please know that Life Insurance is only addressed because benefits are now being billed on one bill. If there are questions regarding the Life Insurance portion of the bill you must contact Group Life Insurance at:

Personnel Cabinet
Office of Employee Relations, Life Insurance Branch
(502) 564-4774 or (800) 267-8352

1. Collections and Disbursements (CD)

The Collections and Disbursements (CD) system is used to facilitate the reconciliation and management of Health Insurance, FSA/HRA and life insurance enrollment data, premiums and contributions. By managing all premiums and contributions, the CD system supports the Commonwealth's self-funded insurance model. The CD system allows for:

- Creation of Health Insurance, life insurance, FSA/HRA bills and administration fee bills using KHRIS Web-billing (Broker Report);
- Reconciliation of Health Insurance, life insurance and FSA/HRA coverage with all agencies and administrators;
- Posting of all premiums, contributions and adjustments; and
- Reporting and resolution of discrepancies.

2. Billing Statements

A. State government agencies

State government agencies do not receive bill statements. KEHP receives a file extract from the state payroll system. Health Insurance, life insurance, FSA/HRA contributions, premiums and administration fees are posted into the CD system automatically from this extract.

Once the extract has been loaded into CD, KEHP will review the results and notify each state agency's Insurance Coordinator of any discrepancies by running an "arrears report" after each payroll has been run.

B. Boards of education

1. Employee Portion of Premiums/Contributions

Boards of education will have a monthly bill statement (semi-monthly for FSA/HRA) generated by CD for the Employee portion of Health Insurance, FSA, Optional and Dependent Life insurance premiums and contributions only. The bill statements will be posted in KHRIS Web Billing (broker report) located at www.kehp.ky.gov.

The 15th bill will include the first half of FSA; the 30th bill will include the last half of FSA and the full month for health and life insurance.

Insurance Coordinators are responsible for reconciling the monthly bills posted on KHRIS Web Billing (broker report) (or semi-monthly for FSA/HRA) to deductions made from the board of education payroll system and adjusting the web bill if necessary. If an Employee is not submitting any premiums or contributions, the line item must be rejected.

Example: the reject function in KHRIS Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the Employee terminates employment (or transfers out) and the person still shows on the bill, or if the Employee did not make a payment for the month. If you remove a record from a bill but the appropriate action has not been taken to change the Employee master data record (including benefits), the record will appear again on the next month's KHRIS web billing broker report. If the termination is due to termination of employment, the Insurance Coordinator should log into KHRIS to complete termination of coverage within 59 days. If the termination is past 59 days, the Insurance Coordinator will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085.

For other terms that don't meet these criteria, the Insurance Coordinator will need to contact KEHP.

It is important to note that the premiums received MUST match the monthly or semi-monthly KHRIS web billing broker report.

2. Employer Portion of Health Insurance, Basic Life Insurance or HRA

KDE pays the employer portion of Health Insurance, HRA and basic life insurance premiums/contributions and the administration fees. Insurance Coordinators or payroll officers with questions related to MUNIS must contact the Kentucky Department of Education (KDE) at (502)564-3846.

C. Health Departments and Quasi Governmental Agencies

Currently, health departments do not participate in KEHP's Flexible Spending Account Program and there are only a limited number of quasi governmental agencies that participate.

The CD system generates monthly (semi-monthly for FSA/HRA) broker reports for health departments and quasi governmental agencies **(**http://personnel.ky.gov/**).**

Insurance Coordinators are responsible for reviewing the monthly (semi-monthly for FSA/HRA) KHRIS broker reports for accuracy and must make any necessary changes.

If an Employee is not submitting any contributions, then the line item must be rejected.

Example: the reject function in KHRIS Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the Employee terminates employment (or transfers out) and the person still shows on the bill or if the Employee did not make a payment for the month. If you remove a record from a bill but the appropriate action has not been taken to change the Employee master data record (including benefits), the record will appear again on the next month's KHRIS web billing broker report. If the termination is due to termination of employment, the Insurance Coordinator should log into KHRIS to complete termination of coverage within 59 days. If the termination is past 59 days, the Insurance Coordinator will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085.

For other terms that don't meet these criteria, the Insurance Coordinator will need to contact KEHP.

3. Detailed Description of the Billing Statements

If your company's HRA and FSA programs are administered by KEHP, you are responsible for completing the HRA and FSA web bill on-line. A separate web bill for all health departments' administration fees is generated for the central office of the health department.

Bills will now only show what the company is responsible for paying:

GROUP	BILLS WILL INCLUDE THE FOLLOWING:			
BOE	Employee Health Insurance	FSAs	Optional Life	Dependent Life
KDE	Employer Health Insurance	Administrative Fee	HRA	Basic Life
HD	Employee Health Insurance	Employer Health Insurance	All Life	
HD Central Office	Administrative Fees			
Quasi	Everything the quasi-governmental company participates in (Employee/Employer Health Insurance, FSA, HRA, Basic Life Insurance, Optional Life Insurance, Dependent Life Insurance and Administrative Fees			

For assistance in processing your monthly bill, go to:

https://persrwd1.personnel.ky.gov/gm/workplace, then KHRIS Training Documentation, Non Commonwealth Paid, Insurance Coordinator, BPPs. Then select the BPP you wish to view and a .pdf document will open that you may print out or save to your computer. You can also close the .pdf and go through the simulations by selecting "simulation" in the drop-down box and clicking on the link "Click here to start the playback tutorial".

Note: Be sure to turn off pop-up blockers.

4. Premium/Contribution Refunds

A. When to request a refund

The following list, while not all-inclusive, defines when a refund may be requested:

- A check is issued in error;
- An Employee terminates at the end of the month and one-half the premium for the following month is deducted and sent to KEHP;
- An Employee is enrolled with the incorrect Plan Option or Coverage Level;
- The occurrence of a Qualifying Event; or
- An Employee is ineligible or becomes ineligible.

B. Time limits to request refunds of Health Insurance premiums/contributions.

Refunds will be restricted to the beginning of the current Plan Year to a maximum period of 60 days, except in the event of the death of a covered person. Note that any mid-year election change resulting in the termination of a covered person will be effective on the date as designated under the terms of KEHP. Therefore, if KEHP receives notification of a termination more than 60 days after the event causing the termination, the premium/contribution will be refunded as shown in the following table:

Notification received in:	Count from:	Months for which premium is to be refunded:
January	January 31	January
February	February 28	January and February
March	March 31	February and March
April	April 30	March and April
May	May 31	April and May
June	June 30	May and June
July	July 31	June and July
August	August 31	July and August
September	September 30	August and September
October	October 31	September and October
November	November 30	October and November
December	December 31	November and December

NOTE: If a refund is due, you can either take it as a credit to your account or submit a written request to KEHP. You must **NOT DO BOTH**.

C. Refunds due to eligibility changes

1. Single Coverage Level

If the Employee dies on the 1st through the 15th of the month, Health Insurance coverage will terminate on the Employee's date of death. No premiums are due. If the Employee dies on the 16th through the end of the month, Health Insurance coverage will terminate on the Employee's date of death. The full month premium is due.

2. Parent Plus, Couple or Family Coverage Level

If the Employee dies, Health Insurance coverage will continue to the end of the month in which death occurs for the Dependents. The full month premium is due. If a Dependent dies and the death causes a Coverage Level change (e.g. family to parent plus), the original level of Health Insurance coverage will continue to the end of the month in which the death occurred and the full month premium is due. The new level of coverage will begin the 1st of the next month and the new premium will begin.

3. Dependent child becomes ineligible.

Employees that experience the Qualifying Event of Dependent child becomes ineligible will be entitled to a refund. However, the time limits for refund requests rules apply.

D. Miscellaneous

KEHP will issue refund checks for any erroneous overpayments. Refund checks, except for those to quasi governmental agencies and school districts, will be made payable to:

- The Kentucky State Treasurer, if the overpayment is to the employer;
- The Employee, if the overpayment is the Employee's portion; or
- Separate checks for both the Employee and the Kentucky State Treasurer, if there is an overpayment of both Employee and employer payments.

Refund checks will be sent to the appropriate Insurance Coordinator or payroll officer no later than thirty (30) days from receipt of the request for refund.

Refund requests must be initiated by either the Insurance Coordinator or the Payroll Officer.

5. Other Payment Information

- If you pay by paper check, make checks payable to the Kentucky State Treasurer.
- Everyone is encouraged to use the Web Billing function called Easy Pay. This function allows the agencies to do an ACH at no cost to the agencies (see the Biller Direct BPP).
- One payment can be submitted for all Health Insurance, FSA, Life Insurance and administration fees.
- Administration fees for health departments and school boards are paid by a central location; therefore, they are not included in the bill total.
- Payments must be mailed to:

  Personnel Cabinet
  Department of Employee Insurance
  Financial Management Branch
  501 High Street, 2nd Floor
  Frankfort, Kentucky 40601

Questions -Contact KEHP Financial Management Branch at (502) 564-9097 or 502-564-0350 for Flexible Benefits.

CHAPTER 13:

GLOSSARY OF TERMS

Glossary of Terms

Biller Direct – A detail view where an Employee/vendor can see a particular bill and the amount of any deductions made or discounts given.

BPP - Business Process Procedure is a document that demonstrates the step by step process for how to complete a transaction in KHRIS. There is a BPP document for every transaction that will be performed in a given area.

COBRA – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows Employees to continue their group Health Insurance coverage for a period of time.

Commonwealth Paid – Employees who are paid and receive benefits from the Commonwealth.

Couple Coverage Level – Coverage for Employee or Retiree and their eligible covered Spouse.

Coverage Level – Single, parent plus, couple or family coverage.

Cross-Reference Payment Option– A husband and wife who, as Eligible Employees or Retirees of KEHP, may elect to have both state paid contributions applied to one Family Coverage Level.

Dependent – A Spouse or Dependent child covered under the Plan.

Dependent Care FSA – A benefit provided through a Section 125 Cafeteria Plan that allows employees to pay for dependent care expenses with pre-tax dollars.

Dual Employment – Employees who are regularly employed with different agencies (i.e. school board and state company) and who meet the benefit eligibility requirements for both employers.

Effective Date – The date on which coverage for a covered person begins.

Eligible Employee – A person who meets the eligibility requirements of KEHP and their employer.

Employee – A person who is employed by a company participating with KEHP and eligible to apply for coverage under KEHP.

Enrollment Application – The form which is used upon hire or during Open Enrollment for an Employee to elect a Plan Option.

Family Coverage Level – Coverage for the Employee, the Employee's Spouse under a legal marriage and one or more Dependent children.

Flexible Spending Account – A tax free account governed by a Section 125 Cafeteria Plan that allows employees to pay for certain healthcare or dependent care (child or adult day care services) expenses with pre-tax money that you set aside through payroll deductions.

Healthcare FSA – A benefit provided through a Section 125 Cafeteria Plan that allows employees to pay for eligible healthcare benefits with pre-tax dollars.

Health Insurance – A health benefit that provides reimbursement for covered eligible expenses due to sickness, injury and certain preventive care treatment after a specified premium has been paid.

Insurance Coordinator – The Human Resources representative within a company who is responsible for advising Employees of any benefits available through KEHP and the governing Cafeteria 125 rules.

Kentucky Employees' Health Plan (KEHP) – The group, which is composed of Eligible Employees of state agencies, boards of education, health departments and quasi agencies. Also Retirees of KCTCS, Retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible Dependents.

Kentucky Human Resource Information System (KHRIS) – A software system that will manage human resources for the Commonwealth.

Late Enrollee – An Eligible Employee who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a Late Enrollee if:

- The person enrolls during their initial enrollment period;
- The person enrolls during any annual open enrollment period; or
- The person enrolls during a Special Enrollment Period.

Member – Any Employee, Retiree, COBRA participant or Dependents that are covered by one of the health plans offered by KEHP.

Non-Commonwealth Paid – Employees who receive life or health benefits from the Commonwealth and are not on the state payroll.

Open Enrollment – A defined period of time, prior to the beginning of a Coverage Period, during which an Employee shall be entitled to elect Plan Options for the subsequent Plan Year.

Parent Plus Coverage Level – Coverage for the Employee and one or more eligible Dependent children.

Planholder – The Employee within KEHP who establishes the plan.

Plan Year – Each successive twelve-month period starting on January 1 and ending on December 31.

Premium Due Date – The date on which a premium is due to maintain coverage under KEHP.

Qualified Beneficiary – Any individual who, on the day before a COBRA Qualifying Event, is covered under the Plan by virtue of being on that day a covered person, or any child who is born or placed for adoption with an Employee during a period of COBRA continuation coverage.

Qualifying Event – A specific situation or occurrence that enables an Eligible Employee to enroll or terminate coverage outside the designated enrollment period for self and/or eligible Dependents, as a result of that person becoming eligible for or losing eligibility for coverage under this Plan or another plan.

Retiree – A Retiree of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Legislators Retirement Plan, Judicial Retirement Plan or any other state retirement system, who is under age 65.

Semi-Monthly Billing Period – For purposes of Health Insurance the semi-monthly billing period is the 1st through the 15th of the month and the 16th through the last day of the month.

Single Coverage Level – Coverage for the Employee/Retiree only.

Special Enrollment Period – A period of time during which an Eligible Employee or Dependent who loses other Health Insurance coverage or incurs a change in status may enroll in the plan without being considered a Late Enrollee.

Spouse – A person of the opposite sex who is legally married to an Employee or Retiree.

Tag-Alongs – Additional Dependents who can be added to the Plan during the course of a valid QE.

Waiver HRA – A Health Reimbursement Account for Employees who waive Health Insurance coverage and who are eligible to receive HRA funds of $175 per month. This is sometimes referred to as a Stand-Alone HRA.

CHAPTER 15:

APPENDICES

Notice to Active Employees Age 65 or Older	Appendix A
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SAMPLE
USE YOUR COMPANY LETTERHEAD

M E M O R A N D U M
TO: *(Employee)*

FROM: Insurance Coordinator

DATE: *(Insert*)

SUBJECT: **Notice to Active Employees Age 65 or Older**

This letter is to inform an active Employee nearing the age of 65 or an Employee 65 or older, of his/her health insurance options upon becoming eligible for Medicare. Any individual age 65 or older (and his/her Spouse age 65 or older) who has current employment status is entitled to the same benefits under the employer's group health plan, under the same conditions as any such individual (or his/her Spouse) under age 65.

The Medicare Secondary Payer rules specify when a group health plan must pay primary and when it may pay secondary if an individual is covered under both a group health plan and Medicare. The rules also provide that employers may not offer individuals entitled to Medicare financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that "take into account" an individual's Medicare entitlement.

Employer-sponsored group health insurance offered to current workers, regardless of Medicare status, is generally the primary payer for individuals covered through their own or a Spouse's *current* employment.

MEDICARE

You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday. Medicare is divided into two main parts, which differ in terms of benefits, eligibility, and administration. Part A is the hospital insurance program. Part B is the supplementary medical insurance program, covering physicians' services and other health care expenses. In addition, individuals who are entitled to these Parts of Medicare may also be eligible for the Medicare Advantage program (Part C) or for certain prescription drug benefits (Part D).

If you are eligible for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

Your Medicare eligibility or enrollment does not affect your eligibility to continue coverage with KEHP as long as you continue to meet the eligibility requirements as an Employee. However, your eligibility to participate in the Kentucky Retirement System(s) Medicare Supplement (KERS/CERS, KTRS, Judicial or Legislative Retirement) plan may be affected.

Under the Medicare Secondary Payer ("MSP") statute, employer group health plans, like KEHP, must pay primary to Medicare for Employees who are eligible for the employer's group health plan ("GHP") coverage by reason of their "current employment status." *See* 42 U.S.C. § 1395y (b); 42 C.F.R. § 411.100(a)(1)(i). If an Employee retires and then returns to work, and the Retiree works enough hours to qualify for coverage (avg. 100 hours/month) under the employer's group health plan for active Employees, federal regulations require the employer to treat the Retiree as an active Employee for purposes of the MSP rules:

> A reemployed Retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other Employees in the same category are provided health

benefits) is considered covered "by reason of current employment status" even if: (1) The employer provides the same GHP coverage to Retirees; or (2) The premiums for the plan are paid from a retirement or pension fund. See 42 C.F.R. § 411.172(d).

EMPLOYEE OPTIONS

NOTE: These are the same KEHP options that every currently employee has as a result of his or her employment and KEHP eligibility.

A. **Health Insurance:** Since you will be eligible to participate in Medicare and KEHP, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for Medicare Part B.

You may choose not to enroll in Medicare Part B and continue in KEHP. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates. Contact your local Social Security office or check the Centers for Medicare/Medicaid Services website to obtain all the information necessary to make your decisions.

B. **Waiver HRA**: You may elect a Waiver HRA in lieu of a KEHP health insurance option. The Waiver HRA benefit provides you up to $2100 per year in a Health Reimbursement Account (HRA). If an employee elects the Waiver HRA, the HRA funds will be primary to Medicare and therefore Medicare will only become primary after the HRA funds are exhausted. The reason for this is under federal law HRA's are considered group health plans and subject to the Medicare Secondary Payer rules.

C. **Waiver No HRA:** You may an elect to waive coverage without health insurance or a Health Reimbursement Account (HRA).

If you have questions, contact your Insurance Coordinator or the Enrollment Branch at 502-564-1205

M E M O R A N D U M

TO: New Employees or Prospective Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for you, your Spouse and/or any of your eligible Dependents because of other Health Insurance coverage, you may be able to make a mid-year change in the Kentucky Employees' Health Plan (KEHP) if you/they lose the other health coverage. If other health coverage is lost, you must request enrollment in KEHP no later than 35 days of the loss.

In addition, if you acquire a new Dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself, your Spouse, and/or your Dependents in KEHP, provided that you request enrollment within 35 days of the date of the event. You will have 60 days from the date of birth to add newborns or newly adopted or placed children. However, if you choose to add other eligible Dependents at that time, the change must be made no later than 35 days.

NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires the Commonwealth to notify you, as a participant in KEHP, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your Summary Plan Description.

Keep this notice for your records.

CHECKLIST FOR NEW EMPLOYEES

Name:		**Social Security #:**	
Company Name:		**Company #:**	

Following is a list of your rights and responsibilities regarding the Kentucky Employees' Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to your Insurance Coordinator at _____ or you may contact KEHP at 888-581-8834.

As a new Employee, I understand that:

_____I have 35 calendar days from my date of employment to make my coverage elections under the Kentucky Employees' Health Plan (KEHP), which includes enrolling in a Health Insurance plan, Flexible Spending Account and/or waiving your Health Insurance coverage. The 35 days are counted beginning with the day after my hire date. My effective date of coverage is _____. If I am an Employee of a company that has a probationary period of three months or more, I must sign and date my application no later than 35 days prior to my coverage effective date.

_____I understand that if I am 65 or older that I have the same opportunity to enroll in KEHP as any other active Employee.

_____I understand that if I am a return to work Retiree age 65 or older and/or Medicare eligible that I may not be eligible to continue under a Medicare supplement plan offered by a retirement system. I must call my retirement system and verify whether I will be eligible for a Medicare supplement or whether I should consider enrolling in a KEHP plan.

_____I understand that if I am Medicare eligible that my KEHP coverage or stand-alone HRA will pay primary over Medicare for covered expenses, up to the limit of my coverage under the KEHP, before applying to Medicare for payment as the secondary carrier.

_____I must make my elections in KHRIS (including a waiver of coverage) **OR** I must complete an Enrollment Application and submit to my Insurance Coordinator.

_____I will be subject to a one time, 12 month waiting period for pre-existing conditions unless I have had prior Creditable Coverage for at least 12 months and have had less than a 63 consecutive day break in coverage between the termination of that coverage and the Effective Date of my coverage with KEHP. Any prior period of coverage that is less than 12 months will be applied against the pre-existing condition waiting period.

_____Once I make my insurance elections, I cannot change those elections for the Plan Year unless I experience a valid Qualifying Event or during the Open Enrollment Period.

_____If I meet all requirements and elect to start a Cross-Reference Payment Option with my Spouse, who is an existing Employee or Retiree of KEHP and one of us terminates employment, the remaining Employee will be set up with a Parent Plus plan.

_____If I fail to enroll within the specified deadline, I will be set up as a waiver with no Health Reimbursement Account. I will only be able to enroll in KEHP a) if a Qualifying Event takes place that would allow me to enroll or b) during the next Open Enrollment Period.

_____Every year there is a defined Open Enrollment Period for KEHP coverage that provides me the opportunity to make ANY change to my KEHP coverage, if applicable.

NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM KEHP COVERAGE, EVEN DURING OPEN ENROLLMENT, UNLESS THERE IS A SUBSEQUENT COURT OR ADMINISTRATIVE ORDER.

_____Outside of the annual Open Enrollment Period, I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans **within 35 calendar days of a Qualifying Event or up to 60 calendar days for newborns and adoptions (see the Benefits Selection Guide, Administration Manual, or Summary Plan Descriptions for more information on adding newborns/adoptions and when they will be effective)**. A list of Qualifying Events is available from your Insurance Coordinator or KEHP's web site at www.kehp.ky.gov.

_____I have been directed to the Summary Plan Description on KEHP's web site (www.kehp.ky.gov) where I can find all relevant information pertaining to my KEHP coverage.

_____I have been directed to the Benefit Selection Guide on KEHP's web site where I can find all relevant information pertaining to my options for Health Insurance coverage.

_____KEHP offers a Premium Conversion program that allows me to pay my portion of the Health Insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in Health Insurance, unless I sign the Post-Tax Form.

_____My coverage will begin no earlier than on the first day of the second month following my employment hire date.

_____If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my Health Insurance at my own expense under COBRA.

_____If I decide that I do not want the state-sponsored KEHP coverage at this time, I can waive (decline) coverage when I enroll either online or by submitting an Enrollment Application. **Check with your Spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.**

_____I may have the opportunity to enroll in the Flexible Spending Account (FSA) program, if applicable, no later than 35 calendar days from my date of employment. I have obtained the appropriate FSA information and application and have been given a chance to ask questions pertaining to the coverage by my Insurance Coordinator.

_____I may contribute my own money into either the Healthcare FSA or Dependent Care FSA. Once I have directed money into the Healthcare FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status (Qualifying Event) if the change is requested no later than 35 calendar days of the date of the event. Changes are allowed to the Dependent Care FSA with an approved Change in Status. Refer to the Qualifying Event Charts.

Have you worked for any other company participating in the Kentucky Employees' Health Plan within the last 11 days?

Yes ___ No ___.If yes, please give name of company and date terminated or transferred.

Company Name: _____Date terminated or transferred:_____

Are you retired from a state-sponsored retirement system?

Yes ___ No ___ If yes, please specify which system:

_____Judicial Retirement Plan

_____Legislators Retirement Plan

_____KCTCS

_____Kentucky Retirement Systems

_____Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the following:

_____Flexible Spending Account Information, if applicable

_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act

_____Other _____

I certify that I have had my Health Insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

_____ _____

Employee Signature **Date**

_____ _____

Company Representative **Date**

SAMPLE

USE YOUR COMPANY LETTERHEAD

M E M O R A N D U M

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an Employee on Leave Without Pay (LWOP), you are eligible to continue your Health Insurance, Health Reimbursement Account and Healthcare Flexible Spending Account at your own expense through COBRA. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits.

Health Insurance

To continue your group Health Insurance coverage you must pay the premiums or you may elect COBRA.

A. If you are on LWOP and you have a pay-check during the semi-monthly period the leave starts, please check with the Insurance Coordinator for your company for information as to when your Health Insurance, stand-alone HRA or FSA coverage will end. If your pay for the semi-monthly period is not sufficient to cover the Employee's portion of the premium, you will need to submit a check for the amount due.

   Any portion of a premium due by you must be submitted to the Insurance Coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer and have your Social Security Number listed on the check. The Insurance Coordinator will forward the payment to KEHP.

   NOTE: If you fail to submit appropriate premium payments due within the specified deadline, the Plan will cancel the ENTIRE POLICY.

B. If you will be on LWOP and lose eligibility under the Plan, you may continue your coverage through COBRA. You will need complete the COBRA election form and submit it, with your payment, to Ceridian. Follow the instructions provided with your COBRA materials.

Health Care Flexible Spending Account

If you are eligible and you decide to continue your participation in the Healthcare FSA, you must submit a check to your Insurance Coordinator, in the amount of $_____ made payable to the Kentucky State Treasurer**.**

When you return to work after being on LWOP, please check with your Insurance Coordinator for information concerning when your coverage will resume.

When you return from LWOP your length of absence may affect your Health Insurance. If you do not elect to continue Health Insurance while on LWOP, and have more than a 63 day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the Health Insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within 35 days of returning to work, except when adding a child ONLY due to birth, adoption, or placement for adoption, which would require you to apply within 60 days.
- You return in a new Plan Year or after missing the Open Enrollment period and you apply for a coverage change no later than 35 days after your return.
- The coverage in which you were enrolled prior to the beginning of the LWOP is not available upon your return. You will have no more than 35 days after your return to apply for an appropriate change.

The Insurance Coordinator must provide the necessary applications upon return. Should you have any questions, you may contact me at _____.

SAMPLE

USE YOUR COMPANY LETTERHEAD

MEMORANDUM

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Medical Leave (FMLA)

This letter is to inform you of your Health Insurance responsibilities as an Employee on Family Medical Leave (FMLA). As an Employee on FMLA, your Employer will continue to make the employer contributions for your Health Insurance or health reimbursement account, if applicable. It is your responsibility to make timely payments of any Employee contribution amounts that had previously been deducted from your check for Health Insurance and/or flexible spending accounts.

Health Insurance

While on FMLA, two conditions must be met in order to qualify for the employer contribution for Health Insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the Employee contribution, if applicable. To continue your Health Insurance you must submit a check made payable to the Kentucky State Treasurer, in the amount of $_____ (Employee contribution). Your check must be received by me before _____(insert date).

Flexible Spending Account *(if applicable)*

If you are enrolled in KEHP's Flexible Benefits program, you may submit a check in the amount of $_____ made payable to the Kentucky State Treasurer. Your check must be received by me before _____(insert date) If you choose to not continue participating in the Flexible Benefits program, your annual election amount will be reduced by the per semi-monthly contribution amounts not deducted during the FMLA period. If you wish to resume your Employee contribution when you return from FMLA, you must complete an FSA Enrollment Change Application.

The payments for Health Insurance and Flexible Spending Accounts should be submitted to the following address by the _____(insert date) of each month. Please include your Social Security Number on each check.

_____

_____

If you exhaust your FMLA time before you are able to return to work, you will be placed on Leave Without Pay (LWOP) and may be eligible for COBRA. If eligible, you will be sent a COBRA notification letter, which allows you to continue your Health Insurance and Healthcare FSA totally at your own expense. Should you opt not to continue under COBRA, you will be restored to your previous benefits immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

Personnel Cabinet

Department of Employee Insurance

Kentucky Employees' Health Plan

2011 MONTHLY PREMIUMS AND EMPLOYEE CONTRIBUTIONS

NON-SMOKER

Commonwealth Standard PPO	Total Premium	Employer Contribution	Employee Contribution*
Single	$486.40	$486.40	$0.00
Parent	$749.84	$741.56	$8.28
Couple	$1,127.80	$845.62	$282.18
Family	$1,253.56	$965.12	$288.44
Family Cross-Reference	$626.78	$626.78	$0.00

Commonwealth Maximum Choice	Total Premium	Employer Contribution	Employee Contribution*
Single	$605.40	$575.42	$29.98
Parent Plus	$861.26	$742.60	$118.66
Couple	$1207.80	$843.02	$364.78
Family	$1377.36	$943.20	$434.16
Family Cross-Reference	$688.68	$644.34	$44.34

Commonwealth Capitol Choice	Total Premium	Employer Contribution	Employee Contribution*
Single	$625.68	$589.14	$36.54
Parent Plus	$909.02	$752.04	$156.98
Couple	$1387.36	$903.38	$483.98
Family	$1537.92	$964.76	$573.16
Family Cross-Reference	$768.96	$717.22	$51.74

Commonwealth Optimum PPO	Total Premium	Employer Contribution	Employee Contribution*
Single	$650.30	$588.78	$61.52
Parent Plus	$905.42	$713.02	$192.40
Couple	$1405.66	$893.88	$511.78
Family	$1565.88	$954.22	$611.66
Family Cross-Reference	$782.94	$714.54	$68.40

*** All Employee Contributions are Per Month**

2011 MONTHLY PREMIUMS AND EMPLOYEE CONTRIBUTIONS

SMOKER

Commonwealth Standard PPO	Total Premium	Employer Contribution	Employee Contribution*
Single	$486.40	$460.90	$25.50
Parent Plus	$749.84	$689.24	$60.60
Couple	$1,127.80	$793.30	$334.50
Family	$1,253.56	$912.80	$340.76
Family Cross-Reference	$626.78	$602.06.	$24.72

Commonwealth Maximum Choice	Total Premium	Employer Contribution	Employee Contribution*
Single	$605.40	$549.88	$55.52
Parent Plus	$861.26	$690.28	$170.98
Couple	$1207.80	$790.70	$417.10
Family	$1377.36	$890.88	$486.48
Family Cross-Reference	$688.68	$619.70	$68.98

Commonwealth Capitol Choice	Total Premium	Employer Contribution	Employee Contribution*
Single	$625.68	$563.86	$61.82
Parent Plus	$909.02	$699.72	$209.30
Couple	$1387.36	$850.96	$536.40
Family	$1537.92	$912.44	$625.48
Family Cross-Reference	$768.96	$692.46	$76.50

Commonwealth Optimum PPO	Total Premium	Employer Contribution	Employee Contribution*
Single	$650.30	$563.66	$86.64
Parent Plus	$905.42	$660.70	$244.72
Couple	$1405.66	$841.56	$564.10
Family	$1565.88	$901.90	$663.98
Family Cross-Reference	$782.94	$689.82	$93.12

*** All Employee Contributions are Per Month**

2011 COBRA Rates

	Single	Parent Plus	Couple	Family
Commonwealth Standard PPO	$496.13	$764.84	$1,150.36	$1,278.63
Commonwealth Maximum Choice	$617.51	$878.49	$1,231.96	$1404.91
Commonwealth Capitol Choice	$638.19	$927.20	$1,415.11	$1,568.68
Commonwealth Optimum	$663.31	$923.53	$1,433.77	$1,597.20
Waiver HRA	$169.58			

2011 COBRA Calendar

Qualifying Event Date	18 Months	36 Months
12/10	06/30/2012	12/31/2013
01/11	07/31/2012	01/31/2014
02/11	08/31/2012	02/28/2014
03/11	09/30/2012	03/31/2014
04/11	10/31/2012	04/30/2014
05/11	11/30/2012	05/31/2014
06/11	12/31/2012	06/30/2014
07/11	01/31/2013	07/31/2014
08/11	02/28/2013	08/31/2014
09/11	03/31/2013	09/30/2014
10/11	04/30/2013	10/31/2014
11/11	05/31/2013	11/30/2014
12/11	06/30/2013	12/31/2014

2011 COBRA Carrier Codes	Group#	Group#	Group#
	P5941	P6070	P6077
	Louisville Area	Lexington Area	No. Ky/Cin Area
Commonwealth Standard PPO	CHLJ	CHMM	CHNP
Commonwealth Maximum Choice	DAI1	DAJE	DAJR
Commonwealth Optimum PPO	CHLW	CHMZ	CHN2
Commonwealth Capitol Choice	ETJM	ETJZ	ETKC
Waiver HRA	DJ4A	DJ3X	DJ4N

County and Group Number Table

FIPS	CO. NO.	COUNTY NAME	AREA	GROUP NO.
001	001	ADAIR	LEX	P6070
003	002	ALLEN	LOU	P5941
005	003	ANDERSON	LEX	P6070
007	004	BALLARD	LOU	P5941
009	005	BARREN	LOU	P5941
011	006	BATH	LEX	P6070
013	007	BELL	LEX	P6070
015	008	BOONE	N.KY	P6070
017	009	BOURBON	LEX	P6070
019	010	BOYD	LEX	P6070
021	011	BOYLE	LEX	P6070
023	012	BRACKEN	LEX	P6070
025	013	BREATHITT	LEX	P6070
027	014	BRECKINRIDGE	LOU	P5941
029	015	BULLITT	LOU	P5941
031	016	BUTLER	LOU	P5941
033	017	CALDWELL	LOU	P5941
035	018	CALLOWAY	LOU	P5941
037	019	CAMPBELL	N.KY	P6070
039	020	CARLISLE	LOU	P5941
041	021	CARROLL	LOU	P5941
043	022	CARTER	LEX	P6070
045	023	CASEY	LEX	P6070
047	024	CHRISTIAN	LOU	P5941
049	025	CLARK	LEX	P6070
051	026	CLAY	LEX	P6070
053	027	CLINTON	LEX	P6070
055	028	CRITTENDEN	LOU	P5941
057	029	CUMBERLAND	LEX	P6070
059	030	DAVIESS	LOU	P5941
061	031	EDMONSON	LOU	P5941
063	032	ELLIOTT	LEX	P6070
065	033	ESTILL	LEX	P6070
067	034	FAYETTE	LEX	P6070
069	035	FLEMING	LEX	P6070
071	036	FLOYD	LEX	P6070
073	037	FRANKLIN	LEX	P6070
075	038	FULTON	LOU	P5941
077	039	GALLATIN	N.KY	P6070
079	040	GARRARD	LEX	P6070
081	041	GRANT	N.KY	P6070

083	042	GRAVES	LOU	P5941
085	043	GRAYSON	LOU	P5941
087	044	GREEN	LOU	P5941
089	045	GREENUP	LEX	P6070
091	046	HANDCOCK	LOU	P5941
093	047	HARDIN	LOU	P5941
095	048	HARLAN	LEX	P6070
097	049	HARRISON	LEX	P6070
099	050	HART	LOU	P5941
101	051	HENDERSON	LOU	P5941
103	052	HENRY	LOU	P5941
105	053	HICKMAN	LOU	P5941
107	054	HOPKINS	LOU	P5941
109	055	JACKSON	LEX	P6070
111	056	JEFFERSON	LOU	P5941
113	057	JESSAMINE	LEX	P6070
115	058	JOHNSON	LEX	P6070
117	059	KENTON	N.KY	P6070
119	060	KNOTT	LEX	P6070
121	061	KNOX	LEX	P6070
123	062	LARUE	LOU	P5941
125	063	LAUREL	LEX	P6070
127	064	LAWRENCE	LEX	P6070
129	065	LEE	LEX	P6070
131	066	LESLIE	LEX	P6070
133	067	LETCHER	LEX	P6070
135	068	LEWIS	LEX	P6070
137	069	LINCOLN	LEX	P6070
139	070	LIVINGSTON	LOU	P5941
141	071	LOGAN	LOU	P5941
143	072	LYON	LOU	P5941
151	076	MADISON	LEX	P6070
153	077	MAGOFFIN	LEX	P6070
155	078	MARION	LOU	P5941
157	079	MARSHALL	LOU	P5941
159	080	MARTIN	LEX	P6070
161	081	MASON	LEX	P6070
145	073	MCCRACKEN	LOU	P5941
147	074	MCCREARY	LEX	P6070
149	075	MCLEAN	LOU	P5941
163	082	MEADE	LOU	P5941
165	083	MEIFEE	LEX	P6070
167	084	MERCER	LEX	P6070
169	085	METCALFE	LOU	P5941

171	086	MONROE	LOU	P5941
173	087	MONTGOMERY	LEX	P6070
175	088	MORGAN	LEX	P6070
177	089	MUHLENBURG	LOU	P5941
179	090	NELSON	LOU	P5941
181	091	NICHOLAS	LEX	P6070
183	092	OHIO	LOU	P5941
185	093	OLDHAM	LOU	P5941
187	094	OWEN	LEX	P6070
189	095	OWSLEY	LEX	P6070
191	096	PENDLETON	N.KY	P6070
193	097	PERRY	LEX	P6070
195	098	PIKE	LEX	P6070
197	099	POWELL	LEX	P6070
199	100	PULASKI	LEX	P6070
201	101	ROBERTSON	LEX	P6070
203	102	ROCKCASTLE	LEX	P6070
205	103	ROWAN	LEX	P6070
207	104	RUSSELL	LEX	P6070
209	105	SCOTT	LEX	P6070
211	106	SHELBY	LOU	P5941
213	107	SIMPSON	LOU	P5941
215	108	SPENCER	LOU	P5941
217	109	TAYLOR	LOU	P5941
219	110	TODD	LOU	P5941
221	111	TRIGG	LOU	P5941
223	112	TRIMBLE	LOU	P5941
225	113	UNION	LOU	P5941
227	114	WARREN	LOU	P5941
229	115	WASHINGTON	LOU	P5941
231	116	WAYNE	LEX	P6070
233	117	WEBSTER	LOU	P5941
235	118	WHITLEY	LEX	P6070
237	119	WOLFE	LEX	P6070
239	120	WOODFORD	LEX	P6070

Chart to Assist in Administering the Qualifying Event of Death

Health Insurance Coverage

Coverage Level	Death of:	Date of Death	Coverage Ends	Premiums
Single	Member	1st – 15th of the month	Date of Death	No premium due
	Member	16th – end of the month	Date of Death	Full month due
Couple Plan	Member	1st – 15th of the month	End of Current Month	Full month due
	Member	16th – end of the month	End of Current Month	Full month due
	Dependent	1st – 15th of the month	End of Current Month	Full month due
	Dependent	16th – end of the month	End of Current Month	Full month due
Parent Plus	Member	1st – 15th of the month	End of Current Month	Full month due
	Member	16th – end of the month	End of Current Month	Full month due
	Dependent	1st – 15th of the month	End of Current Month	Full month due
	Dependent	16th – end of the month	End of Current Month	Full month due
Family Plan	Member	1st – 15th of the month	End of Current Month	Full month due
	Member	16th – end of the month	End of Current Month	Full month due
	Dependent	1st – 15th of the month	End of Current Month	Full month due
	Dependent	16th – end of the month	End of Current Month	Full month due
Family Cross-Reference	Member/ Spouse	1st – 15th of the month	End of Current Month	Full month due
	Member/ Spouse	16th – end of the month	End of Current Month	Full month due
Family Cross-Reference	Dependent	1st – 15th of the month	End of Current Month	Full month due
	Dependent	16th – end of the month	End of Current Month	Full month due

Flexible Spending Accounts and stand-alone Health Reimbursement Accounts

	Death of:	Date of Death	Coverage Ends	Contributions
FSA & HRA	**Member**	**1st – 15th of the month**	**Date of Death**	**½ of the monthly contribution**
	Member	**16th – end of the month**	**Date of Death**	**Full monthly contribution**

Chart to Assist in Administering the Qualifying Event of Birth - Effective May 1, 2011

Pursuant to KRS 304.17A-139, when a newborn is added to KEHP, no additional premiums can be charged for the newborn for the first 31 days. Newborns must be enrolled within 60 days from the date of birth; however, if Tag-Alongs are being enrolled with the newborn, the newborn and the Tag-Alongs must be enrolled within 35 days from the birth and additional premiums can be charged. For the chart below, the newborn baby is born on October 6 and the 32nd day of coverage is on November 7. The enrollment and billing information is segregated by semi-monthly periods to show how an Employee could potentially be enrolled in a specific Coverage Level while being billed for a different Coverage Level.

	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Single to Parent Plus <u>with no</u> Tag-Alongs	Single Coverage Level	Single Coverage Level	Single Coverage Level	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
Bill for:	Single Contribution	Single Contribution	Single Contribution		Single Contribution	Single Contribution	Parent Plus Contribution
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Single to Parent Plus <u>with</u> Tag-Along	Single Coverage Level	Single Coverage Level	Single Coverage Level	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
Bill for:	Single Contribution	Single Contribution	Parent Plus Contribution		Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Single to Family <u>with</u> Tag-Alongs	Single Coverage Level	Single Coverage Level	Single Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level
Bill for:	Single Coverage Level	Single Coverage Level	Family Coverage Level		Family Coverage Level	Family Coverage Level	Family Coverage Level
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Family to Family with or without Tag-Along	Family Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level as of 10/6 with new Dependent	Family Coverage Level	Family Coverage Level	Family Coverage Level
Bill for:	Family Contribution	Family Contribution	Family Contribution		Family Contribution	Family Contribution	Family Contribution
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Parent Plus to Parent Plus with or without Tag-Along	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Level as of 10/6 with new Dependent	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
Bill for:	Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution		Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution

	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Parent Plus to Family with Tag-Along	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level	Family Coverage Level as of 10/6	Family Coverage Level	Family Coverage Level	Family Coverage Level
Bill for:	Parent Plus Contribution	Parent Plus Contribution	Family Contribution		Family Contribution	Family Contribution	Family Contribution
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Two Single to a Family Cross-Reference Payment Option without Tag-Alongs	Two Single Coverage Levels	Two Single Coverage Levels	Two Single Coverage Levels	Family Cross Reference Payment Option as of 10/6	Family Cross Reference Payment Option	Family Cross Reference Payment Option	Family Cross Reference Payment Option
Bill for:	Two Single Contributions	Two Single Contributions	Two Single Contributions		Two Single Contributions	Two Single Contributions	Two Family Cross Reference Contributions
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: One Single and one Parent Plus to Family Cross Reference Payment Option without Tag-Alongs	One Single Coverage Level and One Parent Plus Coverage Level	One Single Coverage Level and One Parent Plus Coverage Level	One Single Coverage Level and One Parent Plus Coverage Level	Family Cross Reference Payment Option as of 10/6	Family Cross Reference Payment Option	Family Cross Reference Payment Option	Family Cross Reference Payment Option
Bill for:	One Single Contribution and One Parent Plus Contribution	One Single Contribution and One Parent Plus Contribution	One Single Contribution and One Parent Plus Contribution		One Single Contribution and one Parent Plus Contribution	One Single Contribution and one Parent Plus Contribution	Two Family Cross-Reference Contributions
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Waiver HRA to Parent Plus (Employee is Tag-Along)	Waiver HRA	Waiver HRA	Waiver HRA	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
Bill for:	Waiver HRA	Waiver HRA	Single Contribution		Single Contribution	Single Contribution	Parent Plus Contribution
	September 1st-15th	**September 16th-31st**	**October 1st-15th (Newborn born on 10/6)**		**October 16th-31st**	**November 1st-15th**	**November 16th-31st**
Coverage Level: Waiver HRA to Family (Employee, Spouse and Children as Tag-Alongs**)**	Waiver HRA	Waiver HRA	Waiver HRA	Family Coverage Level as of 10/6	Family Coverage Level	Family Coverage Level	Family Coverage Level
Bill for:	Waiver HRA	Waiver HRA	Couple Contribution		Couple Contribution	Couple Contribution	Family Contribution

Chart to Assist in Determining the Effective Date of Coverage

Coverage for new Employees will begin on the first day of the second calendar month following the Employee's hire date. Example: if employment begins anytime in August, the Employee is eligible for coverage October 1.

Employees Hired During the Month of:	Will Have Coverage Effective
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1